State of Maryland / Department of Health and Mental Hygiene 2007

			1 - State of Maryland / Department	ent of Health and I a <i>te of Death</i>	Mental Hygie Reg.	ne2007	29001
	3	Э	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medio		LEON BIRCHBY BRIDGETT		SEPT.2,	2007	2:00A M
	Examin	er	4a. Facility Name (If not institution, give street and number) CHARLES CO.NUR. & REHAB CENTER	ty, Town, or Location of Death LA PLATA		4c. County of Death	
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un	der 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		213-16-277 1 1 M 2 F 84 Yrs. Month	ns Days Hours Min.	6-18-19	23 MAT	(YLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mary a-f she ified a	ctor	MD. CHARLES LA	PLATA			1 X Yes 2 □ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	al Director	10e. Street and Number 10200 LA PLATA ROAD	Zip Code 20646		Citizen of What Cou	intry?
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De Armed Forces? 13. Was De If Yes, s	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
980	urs after al', or it	þ	1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ No	2 No Specify:		Specify: WI	HITE
21215-0036	"natul	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of User No. 2004)	sual Occupation work done during most of wor Fuse retired)	king 16t	b. Kind of Business/l	ndustry
121	filed within Hygiene. Sther than " ent, the Med	omp	Elementary/Secondary (0-12) College (1-40r 5+)	Y DRIVER		CAL 33	UNION
pu	al Hygie I other vent, tt	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	iden Surname)	
ylaı	should be filed withir and Mental Hygiene. s marked other than iumatic event, the M	To	ODEN DENNIS BRIDGETT	ess (Street and Number or Ru		St Town Of to 7	i- 0- da)
Maryland	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relationship (Type. Print) EVELYN P.BRIDGETT-SPOUSE 4065 O	LD WASH.RD.	WALDORF,	, MD . 2060	2
Baltimore,	ges 1 and 2 it of Health if item 27 or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	or other place)		c. Location - City or	
ţ	Pag tment tant: i		4 □ Donation 5 【XOther (Specify) ENTOMBMENT TRINITY	MEM.GARDEN	9-6-07 WZ	ALDORF, M	D.
Bal	permit. Pages 1 Department of H Important: if ite any injury or ot		21. Signature of Funeral Service Licensee M00479 22. Name RAY	and Address of Facility MOND FUNERAI PLATA, MD. 2(SERVICE	E, P.A.	
Nya.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the r	node of dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition resulting in death)	al Infacci	100		Hours
1	/Medical Examiner		Due to (or as a consequence of):	73/00			Years
0	D #=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
ys-	ecuter and I-trans	Examiner	Cause (Disease or injury that initiated events c				
68760,	tificate be executed ig physician and as the burial-transit	edical E	d.				
_	ntificat ng phy s as th		IF FEMALE:				
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome pr pregnancy 1 Live birth 2 Fetal death 3 Ectopi 4 Pregnant at time of death 5 Other	c pregnancy (specify)		23d. Date of deli Month	very Day Year
P.0	hat the de d by the letached	Phy	9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying	o cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Vital Records,	uires that n signed k	d by	Diabetes Mellitus, aurtic		1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
COL	aw requir s been si 2 should l	Completed			24a. Was an	24b. Were au	topsy findings available
I B	The lavate has	Som	disease pementia		autopsy performe 1∐ Yes 2□	d? death?	completion of cause of 2 ☐ No
Vita	Physician: The riths certificate haral director, page	Be	25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)		
0	Phys rthis ral di	: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?	fome 5 ☐ Residence 28d. Describe how		cify)
ion	ath. or: After he funer	atior	1 Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M	1 Yes 2 No			
Division	or Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, face building, etc. (Specify)	etory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	red at the time, date and place tion, in my opinion, death occ	e, and due to the causurred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier	29c, License number		Date signed (Monta	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1135U Penbrooke Square, We	DUU 61616	6	Sept. 300	,200+
-			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	R. SINDHINGS	12/		
	10		11350 Pembrouke Square	eldar M	á '		

State Registrar 31. Date filed (Month, Day, Year) SEP 11 2007

For		Otato or i	riai y laria	-		Health and			20=	00000	
State Registrar				Cei	rtificate of	⊔eath		eg. No. 2	JU7	29002	
	(First, Middle, Las						2. Date of Deat Month	Day	Year	0/20 A M	
	n K. Beac				4h City Town	or Location of Deat	08	26 Cour	2007	UIZU A "	
Facility Name (If	not institution, give	e street and number	er)	rente	,	SALISBUA			4 com 1	is	
Social Security Nu	umber 6. S	ex 7.	Age (In yrs. la.	c TTTL(st birthday)	If Under 1 Yea	If Under 24 Hrs.	8. Date of Birth	Va a :: 1	9. Birthp	lace (State or Foreign	
221-10-13	310	⊠ M 2□F	88	Yrs.	Months Days	Hours Min.	Feb. 13,				
a. State	10b. County		10c. City,	Town or Lo	ocation				1	0d. Inside City Limits	
1D	Wicomic	:0	Sali	isbury	y					1 AYes 2 No	
e. Street and Nun	nber				10f. Zip Code		1	0g. Citizen o	of What Coun	try?	
	lthway Dr	ive			2180)4		U.S.	Α.		
. Marital Status	<i>J</i>	12. Was Decede	nt Ever in U.S	. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No-		ace - Americ		
1 Never Marri	ed 2K Married		^{ns} № 1941		1 ☐ Yes 2 ☒ No		to moun, etc.		_{cifv:} whi		
3 🗆 Widowed	4 ☐ Divorced	Year or Date	s: 1945		ILLIES ZENIN	. ороспу.			ony.	als, ce	
	15. Decedent's Ed	ade completed)		(Give	dent's Usual Occ kind of work don DO NOT use retir	during most of wo	orking	16b. Kind of	Business/Ind	dustry	
Elementary/Secon	ndary (U-12)	College (1-4	DI 5+)	millwright nylon co						pany	
'. Father's Name ((First, Middle, Last,)		18. Mother's Name (First, Middle, Maiden Surname)							
Kendal B	. Beach					Nema	0wens				
a. Informant's Na	ame/Relationship (Type. Print)		19b. Maili	ng Address (Stree	et and Number or R	lural Route Number	, City or Tov	vn, State, Zip	Code)	
Patricia	B. Naugl	le (Daug	hter)	210	N. Hant	verker Dr	ive_Delr	nar, D	E 199	40	
a. Method of Disp	position		20b. Pla	ace of Disp	osition (Name of matory or other p	ace)	Date	20c. Locatio	n - City or To	own, State	
	☐ Cremation 3 ☐ 5 ☐ Other (Specif		ate I			tery Aug.	29, 2007	Delm	ar, De	laware	
	ineral Service Lice		-			ress of Facility					
100	Azwell	1				Grove Str		Lmar,	DE 19	940	
3a. Part1. Enter the	he disease, of com	prications that cau	sed the death.	Do not en	iter the mode of d	ring, such as cardia	ac or respiratory arr	est,		Approximate Interval Between	
nmediate Cause (Final		v03016	and An	(and	AVUVIII	lau disce	45-		Onset and Death	
sease or condition sulting in death)		a	as a consequ	-	CA PO	o o vi wall	NIN 61 - 6				
		h									
equentially list col any leading to in ause. Enter Unde	nditions,	Due to jor	as a consequ	ence of):							
ause (Disease or at initiated events	injury	C									
sulting in death) l	Last	Due to (or	as a consequ	ence of):							
		_ d									
F FEMALE: 3b. Was deceden		23c. If yes, outco	me pf pregnar h 2 □ Fetal		□Ectopic pregna	icv		23d.	Date of delive	*	
in the past 12 1 ☐ Yes 2 [nt at time of de		Other (specify)				Month	Day Year	
9 Unknown				-							
art II. Other signif	ficant conditions	contributing to dea	th but not resul	Iting in the	underlying cause	jiven in Part I.		bacco use c es 2□ N		the cause of death? bably 4 Don know	
							24a, Was a	n 24	th. Were auto	opsy findings availabl	
							autop perfor	sy med2	prior to co	impletion of cause of	
							1□ Yes	2[] No	1 ☐ Yes	2[4No	
		1 '									
5. Was case refer examiner? 1 ☐ Yes 2 ☑	_	Hospital:	patient 2 🗆 🛭			thor.	eath <i>(Check only or</i> Home 5 Resid				

Physician /Medical Examiner

use as the burial-tran and attending physician for use as the burial been signed by I should be detach

Be Medical Certification: To

ysician/Medic	IF FEMALE: 23b. Was deceding the past 1 ☐ Yes 9 ☐ Unkno
d by Phy	Part II. Other sig
Complete	

To the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has funeral director, page 2: within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Division or Vital Records, P.O. Box 68760,

State Registrar

al Examiner

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

Director

Funeral

To Be Completed by

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

5 Pending

investigation

6 Could not be determined

2 ER/Outpatient 3 DOA 1 inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred injury 1 ☐ Yes 2 ☐ No

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Coour

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHESH MANNER WYS 106 MITHAUL ST SOUTS COLLIER MY 2180 4.

31. Date filed (Month, Pay Year) 8 2007 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Isabelle J. Bennett August 24 2007 5:48 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Nursing Home Salisbury Wicomico If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 M 2 X 93 Director 214-10-8669 2/7/1914 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State show 10d. Inside City Limits irai", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 🔀 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 1105 S. Schumaker Drive 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2X No Specify: white 3 XWidowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed with Health and Mental Hygiene. legal secretary office equipment Important: If item 27 is marked othe any injury or other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles L. Johnson 2 Aline Duffy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles w. Bennett III/son 1816 Blakefield Circle, Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 8/28/07 Salisbury, MD of Fungral Service License Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 KIU 28a. Part. Enter the disease, or complications that caused the spock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) =MENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f ☐Yes 2 🗹 No 9□Unknown 9 ☐ Unknown signed by 1 d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has le 2 autopsy page this certificate death? 1 □Yes 1□ Yes Physician: 25. Was case referred to medical examiner?
1 ☐ Yes D☐ No Be 26. Place Death (Check only one) Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending 5 ☐ Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital Medical completely

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

07-0 Johr

Me

Exami	ian/	1- For State Registrar 1. Decedent's Name (First, Middle,L	_ast)	Certificati	e of Death		2. Date of Death	. No. Day Year	3. Time of Death
A.C.IIII	iner	John Henry Barker					August 21,	2007	2110 hrs
		4a. Facility Name (if not institution, and 14400 Home Crest Road	•		4b. City, Town, or Silver Sprin	Location of Death		4c. County of Dea Montgomery	
neral				n yrs. last birthda			8. Date of Birth	(MM/DD/YYYY) 9. E	
ector				4	Yrs. Months Day		Jan 8, 19	For	eign Country) NJ
any		10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
. ₹	-	MD Montgome:	rv	Silv	er Spring				1 Yes 2XX No
8a-f s at on	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What.Co	ountry?
23a or 2 notified	Dire	14400 Homecrest Road	đ		20906			USA	
ns 23. be no	ral	11. Marital Status	12. Was Decedent Eve	er in U.S. 1	3. Was Decedent of Hi				erican Indian, Black,
or ite must	Funeral	1 X Never Married 2 Marri	ied Armed Forces?	No	If Yes, specify Cuba	i, Mexican, Puerto F	Rican, etc.)	White, etc.	
al", c	by F	3 Widowed 4 Divorce	or Dates:		1 Yes 2 X No			Specify:	White
riggiene. other than "natural" the Medi al Examiner		15. Decedent's Education (Specify			cedent's Usual Occupa ing most of working life			16b. Kind of Busines	s/Industry
tent of Health and Montal Hygiene. ant; If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once.	plet	Elementary/Secondary (0-12) 11	. College (1-4 or 5+)					Deiroto	
her t	Completed	17. Father's Name (First, Middle, La	pet)	Man	ntenance Work	18.Mother's Name (First Middle Ma	Private	
ed oth	Be C	William Barker	ist/			Amia	Harry	ilden Sumame)	
marked c event,	To B	19a. Informant's Name/Relationship	(Type, Print)	19b. I	Mailing Address (Stre			er, City or Town, Sta	ate, Zip Code)
tem 27 is n traumatic	_	Barbara Davis /Niece	е		Windridge Cou				
item r trau		20a. Method of Disposition			Disposition (Name of ce	metery,	Date	20c. Location - City	or Town, State
Important: If item injury or other trai	1	1 Burial 2 X Cremation			orotherplace) itan Cremator	v Aug 2	3 2007 A	lexandria,	17A
ortan ry or	8	4 Donation 5 Other Spec	ify:	TE GEOPOI	22. Name and Addres				
Imp		/ Vllakolle)	Monde)	500 Universit				
ician		23a. Part I. Enter the disease, or co		death. Do not e	enter the mode of dying	such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval
dical		failure. List only one cause on Immediate Cause (Final disease	a. Hypertensive Athe	erosclerotic (Cardiovascular Di	sease			Between Onset and Death
niner		or condition resulting in death)	Due to (or as a consequent						
		Sequentially list conditions,	b						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequent	ence of):					
	am	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ence of):					
ı and - transit	Ě	overlie resoluting in deatily reast	d.						
	lical	UNPENDED	AMENDED						
3. 2.	Mec	IF FEMALE:	23c. If yes, outcome of	of pregnancy			•	23d. Date of deliv	ery
ohysicia ne buria		23b. Was decedent pregnant in the	1 Live birth	2	Fetal death 3	Ectopic pregnan	су	Month	Day Year
ding physicia e as the buria	an/I	past 12 months?	A Pregnant at time	e of death 5	Other (Specify)				
attending physici or use as the buri	sician/	1 Yes 2 No 9 Unkno						<u> </u>	
he attending physici d for use as the buri	Physician/I	1 Yes 2 No 9 Unkno	own g Unknown	it not resulting in	the underlying cause	niven in Part I	23e. Did tob	acco use contribute.	to the cause of death?
he attending physici d for use as the buri	by Physician/Med		g Unknown	it not resulting in	n the underlying cause	given in Part I.	23e. Did tob		to the cause of death?
igned by the attending physici be detached for use as the buri	by	1 Yes 2 No 9 Unkno	own g Unknown	ut not resulting in	n the underlying cause	given in Part I.	1 Yes	2 No 3 P	robably 4 🗸 Unknown
nas been signed by the attending physici 2 should be detached for use as the buri	by	1 Yes 2 No 9 Unkno	own g Unknown	ut not resulting ir	n the underlying cause	given in Part I.	1 Yes 24a. Was ar autopsy	2 No 3 P	robably 4 Unknown autopsy findings available o completion of cause of
has been signed by the attending physici 2 should be detached for use as the buri	by	1 Yes 2 No 9 Unkno	own g Unknown	ut not resulting in	n the underlying cause	given in Part I.	1 Yes	2 No 3 P 24b. Were prior t death	autopsy findings available o completion of cause of
icate has been signed by the attending physici page 2 should be detached for use as the buri	e Completed by	Part II. Other significant condition 25. Was case referred to medical	g Unknown s contributing to death bu	ut not resulting in		e of Death (Check o	1 Yes 24a. Was ar autopsy perform 1 ✓ Yes 2	2 No 3 P 24b. Were prior to death	autopsy findings available o completion of cause of
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his certificate has been signed by the attending physici director, page 2 should be detached for use as the buri	To Be Completed by	Part II. Other significant condition 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death	g Unknown s contributing to death bu	2 ER/Outp	26.Plac atient 3 DOA ne of injury 28c. Injury	of Death (Check of Other Nursing Iry at Work?	1 Yes 24a. Was ar autopsy perform 1 Yes 2 nly one) Home 5 R	2 No 3 P 24b. Were prior t death No 1	autopsy findings available o completion of cause of? Yes 2 No
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DHMH 17 Rev 1/2001 OCME 2006

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

To the Hospital within 24 hours a To the Funeral C completely filled in

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

ee MD

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Lee MD. 610 Solarex Ct. Frederick Md 21703

31. Date filed (Month, Day, Year) 9 2007

	- 77	1 - For State Registrar 1. Decedent's Name (First, Middle, L.	ant)		ertificate of	Dealli	2. Date of De	Reg. No. 2	.007	
ysici Jedio		Barbara E. Be	eard				Month August	Day 26	^{Year} 2007	3. Time of Death 8:31 P
amir	ner	4a. Facility Name (If not institution, g 4980 Tall Oaks	•		4b. City, Town, o		ath	4c. Cou	unty of Death Frede1	rick
eral ctor		5. Social Security Number 6. 094-36-9182	Sex 7. Age	67 (In yrs. last birthday				ay, Year)	9. Birthp Coun Engla	elace (State or Forei etry) and
m m		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					0d. Inside City Lim
notifled	Director	Maryland Frede	erick	Mo	onrovia 10f. Zip Code	<u> </u>		10g. Citizen	of What Coun	1 □ Yes 2X N
ist be	a D	4980 Tall	Oaks Drive		21	.770		Uni	ted Sta	ates
event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 XNo	lispanic Origin? (an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)		Race - Americ Black, White, ecify:	
Medical E	Completed	15. Decedent's l (Specify only highest g	Education grade completed) College (1-4or 5-	(Giv	edent's Usual Occup le kind of work done DO NOT use retire	pation during most of w d)	rorking	16b. Kind o	of Business/Inc	dustry
the .	E O	8	College (1º40) 5		Presiden	t Sales		Music	and Ar	ts
itic event	To Be (17. Father's Name (First, Middle, Las Jack Ellear	•				ame <i>(First, Middle</i> e Atkins		rname)	
anma		19a. Informant's Name/Relationship	(Type. Print)	19b. Mail	ling Address (Street	and Number or I	Rural Route Numb	er, City or To	wn, State, Zip	Code)
other traumatic		Rene Cook / Son		498	0 Tall 0a	ks Drive				
-		20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	cify)	Arlingto	position (Name of ematory or other place on Nations	1 9/1	3/2007	Arlin		Virginia
any injury o once.		21. Signature of Funeral Service Lice	Stauffe	7	22. Name and Addre		Stauffe 1e Blvd.			
ian		23a Part1. Enter the disease, or conshock, or heart failure. List onl		the death. Do not er	nter the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,		Approximate
		Immediate Cause (Final	Auto						<u> </u>	Interval Between Onset and Death
ical ner		disease or condition resulting in death)	a. Aut C						<u>+</u>	
ner	Examiner	disease or condition	Due to (or es a	a consequence of):						
as the burial-transit	edical Examiner	disease or condition resulting in death) Sequentially list conditions, litery leading to limit of the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or es a	a consequence of):					-	
for use as the burial-transit	ledical	disease or condition resulting in death) Sequentially list conditions, litery leading to limit of the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or es a	a consequence of): a consequence of): a consequence of): of pregnancy 2 Fetal death 3		Kpitci		Heat	Date of delive	Onset and Death
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State Registrar 31. Date filed (Month, Day, Year) AUG 2 9 2007 32. Registrar's Signature

			For State		State of W	-	Departmen Certificat				Reg. No. 2	דחח	2900
	118		Registrar 1. Decedent's Name	(First, Middle,	Last)					2. Date of De		007	3. Time of Death
	Physici		CHAR		7		BRON	1001	CZ	Month Adgust	Day 25 2	Year	00:50 AM
100	/Medic Examin				give street and number)		4b. City,	Town, or Locat	tion of Death	(Is Just		ty of Death	
a d			THE JOH	INS HO	PKINS HOS	PITAL	BA	LTIMO	RE C	ITY			
	Funeral		5. Social Security No	umber 6		ge (In yrs. last bir	Months	1 Year If Ur Days Hou		8. Date of Bi (Month, Da	rth ay, Year)	9. Birthi	place (State or Foreign
I	Director		221-34-6 Usual Residence of		183 W 201	58	Yrs.				3,1949		nington,DE
and	M II		10a. State	10b. County		10c. City, Towr	or Location						10d. Inside City Limits
Mary	rf sh	ţō	DE	Kent		Smyrn	a						1 □Yes 2 No
th the	or 28a e noti	irec	10e. Street and Nun	nber			10f. Zip	Code			10g. Citizen o	f What Cou	ntry?
th wit	23a c ust be	al	217 Juli	ia Way				19977			USA	A	
G Z IZIS-UUSO filed within 72 hours after death with the Maryland	tems er m	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?	7	13. Was Deced	dent of Hispanio	с Origin? (Sp xicaп, Puerto	ecify Yes or No Rican, etc.)		ace - Americ	
s afte	", or I	by F	1 ☐ Never Marri	_	d 1∰Yes 2☐ If Yes, Give Year or Dates:	10/0	1 ☐ Yes	2 ™ No Spe	ecify:		Spec	cify: W	hite
5-UU30 72 hours af	teral Ey	ed	3 🗆 Widowed	15. Decedent's			Decedent's Usua	al Occupation	_		16b. Kind of	Business/In	dustry
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d with	giene er tha the	ĕ	12		College (1-40)	эт, а	ssembly	line			Chry	sler	
d be file	d oth	Be (17. Father's Name (ast) nowicz,Sr.						e, Maiden Surna	ame)	
Va ould I	Meniarke	ပ္			-					Baran			
Viar 12 sh	h and 7 Is m traum		19a. Informant's Na				. Mailing Address						,
1 and	Healt em 2 ither		Ryan Bro		(son)	20b. Place of	1341 Lyn Disposition (Namery, crematory or of	n Drive		hany Be Date	20c. Location		
ages	Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2	☐Cremation :	3 □Removal from State	, 1						•	
baltimo bermit. Pages	artme ortan Injur	1 3	4 □ Donation 21. Signature of Fu			Gracer	awn Mem. 22. Name an				New (
be d	lmp any onc	100	neit	De I	Tiroll	elli	McCrer	y Funer	ral Ho	mes, In	ic. 3924	Conc	ord Pike
			23a. Part1. Enter the	ne disease, or o	complications that cause nly one cause on each I	d the death. Do r	not enter the mod	mingto e of dying, suc	h as cardiac	or respiratory a	arrest,		Approximate Interval Between
Ph	ysician		Immediate Cause (disease or condition	Final	-	PIRATO	PY F	ALLUR	E				Onset and Death
	Medical		resulting in death)			a consequence		LILLUN					1 day
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ped	ısıt	9	fi any, leading to im- cause. Enter Unde	riving	- Due to for as	a consequence	017.						J
acu		-E	Cause (Disease or	iniurv	A							I .	rs
- ×	า and al-trai	xami	Cause (Disease or that initiated events resulting in death) L	injury	c. Acur Due to (or as	TE MY	ELOID	LEUKE	EMIA				3 Years
be exe	siclan and burial-tra	sal Examiner	Cause (Disease or that initiated events	injury	V1			LEUKE	EMIA				3 Years
oo/ou, tificate be exe	g physiclan and as the burial-transit	edical	Cause (Disease or that initiated events resulting in death) L	injury	V1			LEUKE	EMIA				3 Years
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Registrar DHMH 17 Rev 1/2001

	1- For State Certificate		Reg. No. 2007 290
Physician/	1. Decedent's Name (First, Middle,Last) Charles Michael Brown	2. Date of D Month	Day Year 4540 h
ical Examiner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	23, 2007 1510 nrs 4c. County of Death
	3035 West Liberty Road	New Windsor If Under 1 Year If Under 24Hrs. 8. Date of	Carroll Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 15-42-6137 6. Sex 7. Age (In yrs. last birthday 6. Sex 65	'	27, 1941 Foreign West Carringinia
a year	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits
≱	Maryland Carroll	New Windsor	1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Number 3035 West Liberty Road	10f. Zip Code 21776	10g. Citizen of What Country? USA
or items must be	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No specify:	No- 14. Race - American Indian, Black, White, etc. Specify: White
tural"	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Dece	edent's Usual Occupation (Give kind of work done	
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 4	ng most of working life. DO NOT use retired) Buyer	Grocery Store
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medics Be Comple	17. Father's Name (First, Middle, Last) Charles William Brown	18.Mother's Name (First, Midd Virginia	
MD 212 MD 212 d 2 should be lith and Ment m 27 is mark aumatic even To (B	40- Informantia Nama/Relationship /Type Print) 19h M	ailing Address (Street and Number or Rural Route 7 Winchester Drive, West	minster, MD 2115/
Baltimore, MID 21215-0036 Departing 18 and 2 shouldbe filed within 72 hours after a nearly 18 and Montal Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. To Be Completed by 1	1 Permayal from State crematory	sposition (Name of cemetery, or other place) een Memorial 8/27/200	
Baltir Permit: 1 Departm Importa injury of	21. Signature of Funeral Service Licenses M01191	22. Name and Address of Facility Myers—I 91 Willis Street, West	Durboraw Funeral Home Eminster, MD 21157
Physician Luical caminer	23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	nter the mode of dying, such as cardiac or respirator	
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.		
ed nsit Examiner	if any, leading to immediate buse to (or as a consequence of): CDisease or injury that initiated		
d ansit	events resulting in death) Last Due to (or as a consequence of):		
0, e be executed ysician and burial - transit	UNPENDED AMENDED		
ox 6876 ath certificat attending phy or use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year
O. Bo nat the dee d by the stached of	Part II. Other significant conditions contributing to death but not resulting in	Tallo diladitying daddo giron in r artir	Did tobacco use contribute to the cause of death?
s, P.O. Lires that the signed by d be detache ed by Pl			Yes 2 ✓ No 3 Probably 4 Unknown Was an 24b. Were autopsy findings available
of Vital Records, ing Physician: The law requires After this certificate has been signeral director, page 2 should be in: To Be Completed			autopsy performed? Yes 2 No 1 Yes 2 No
tal Recition: The certificate rector, page	25. Was case referred to medical	26. Place of Death (Check only one)	
ion of Vit tending Physic leath. tor: After this of the funeral dire	1 Yes 2 No Inpatient 2 ER/OUD	atient 3 DOA Other Work? Nursing Home 28c. Injury at Work? 28d. Des	5 Residence 6 Other: Scene cribe how injury occurred
Division o Division o Division of Attending within 24 hours after death To the Funeral Director: Aft completely filted in by the fune Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	n, street, factory, office building, etc. 28f. Loca	tion (Street and Number or Rural Route Number, City own, State)
To the Hospits within 24 hours To the Funera completely filling Medical Ce		occurred at the time, date and place, and due to the estigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. date and place, and due to the cause(s)
≥	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
WIL oc	30. Name and addr 25 of person who completed cause of death (Item 23a)	O.C.M.E.	August 24, 2007
~		444 D Olivert Deltimente MD 0400	14
Stat	Mary G. Ripple MD. Deputy Chief Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature	111 Penn Street, Baltimore, MD 2120	11

State of Maryland / Department of Health and Mental Hygien 2007

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			1 - State Registrar				Cer	tifica	te of L	Death			Reg. No.		•		
			1. Decedent's Name (First, Middle	e, Last)								2. Date of De			· · · · ·	3. Time of De	ath
	Physici		I	da B	erman							Month August	Dey 23		Yeer 2007	2:50	ам
,	/Medic Examin		4e. Fecility Name (If not institution					4b. City	. Town, or	Location of	of Death	1146456	3	County		1	
	Examil	lei	Arbor Place											Mo	ntaam	0.257	
	Formula		5. Social Security Number	6. Sex	7. Ag	je (In yrs. last i	birthday)	If Unde	r 1 Year	kville If Under:		8. Date of Birt	h .	PiC	ntgom 9. Birthp	lece (State or Fe	oreign
	Funeral Director		579-60-9729	1 ☐ M 2 🗵	_	102	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	201	Coun	try)	
	Director		Usual Residence of Decedent						l			November	20,1	704	DISTI	ict of Co	Tunit
	iand		10a. State 10b. County			10c. City, To	wn or Lo	cation							1	0d. Inside City L	imits
	Mary	5	Maryland Montg	omary					Por	ckville						1 Yes 2	No
	28a	Directo	10e. Street and Number	Omer y				10f 7i	p Code	-KVIIIE		T	10g Citi:	zen of W	hat Coun	itry?	
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7		S	11. Marital Status	Arme	d Forces?		13. 1	Yes, spi	ecify Cuba	in, Mexican	n, Puerto	ecify Yes or No Rican, etc.)			, White,		
9	be filed within 72 nouts after death with the Maryland tal Hygiene. Ital Hygiene. do other than "natural", or itema 23s or 28s-f show event, the Modical Examiner must be nutified at	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yes	res 2⊠ s, Give	NO	1	☐ Yes	2⊠ No	Specify:				Specify:		White	
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N	Hygiene. Hygiene. other thar			(ant)				по	memake		ria Nama	(First, Middle,	Maidan		ivate		
Maryland	d of	Be	17. Father's Name (First, Middle,	Lasi)						10. MOLITE	s Name	(FIISI, MIDDIE,	Malueri	Sumame	9)		
<u> </u>	should be and Mental a marked o	ပ္	Samuel Ko									7	nown				
	and and in m		19a. Informant's Name/Relations	hip (Type, Print			9b. Mailin	g Addres	s (Street a	and Numbe	er or Rura	il Route Numbe	er, City of	Town, S	State, Zip	Code)	
2	s 1 and 2 should I Health and Mer Item 27 ie merke other traumatic		Marilyn Berman	Pollans	- Daug					e Court		1, Rockv					
e i	of H Titer		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation	3 Fillowayal 6	irom State	20b. Place ceme	of Dispo- tery, cren	sition (Na natory or	me of other plac	e)		ate	20c. Lo	cation - (City or To	wn, State	
Ĕ	Pag nent int: I		'4 □Donation 5 □ Other (S		TOTT State		Israe	1 Cem	etery		8/27	/2007	Wasi	hingt	on, D	.C.	
altimore,	permit. Pages 1 an Department of Heali Important: If Item 2 any injury or other once.		21. Signature of Funetal Service	Licensee 1	111.	-				ss of Facilit		T					
מ	Depa impo		Kalphi	Illd	llie	442	6 · L					lome, Inc nue. Sil		oring	. Mar	yland 209	04
11	146 27		23a. Part 1. Enter the disease, or	complications t	hat cause	d the death. D										Approximate Interval Between	
	the section of		shock, or heart failure. List Immediate Cause (Final													Onset and Dea	ath
	hysician /Medical		disease or condition resulting in death)	a		al Infar										Immediate	:
	Examiner					Atheros		ai a								3 months	
		7	Sequentially list conditions if any, leading to immediate	D		a consequence		212								3 months	
]	nsit	n in	cause. Enter Underlying Cause (Disease or injury			,	,										
	and and I-trai	Examiner	that initiated events resulting in death) Last	c	e to (or as	a consequenc	e of):										
9	De e ician buria				•	,	,										
68/60,	centificate be executed ding physician and se as the burial-transit	/Medical		d													
×	ding	/Me	IF FEMALE:	23c If yes	outcome	of pregnancy					-						
	ath a	an	23b. Was decedent pregnant in the past 12 months?	101	ive birth	2 Fetal dea			regnancy				2	Mon	of deliventh	Day Yea	ar
	0 0	S	1 ☐ Yes 2 ☒ No 9 ☐ Unknown		regnant a Jnknown	t time of death	51_	Other (s	pecify)								
о. О	The law requires that the de ate has been signed by the a page 2 should be detached f	Physician			to double b		n in the second			in Oard I		220 Did t	nhaasa u	oo oontri	buta to th	ne cause of dear	th?
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0	eral	h: T	27. Manner of Death	28a. [Date of Inju	iry 28t	. Time of		28c. Injun Work		-	28d. Describe l				THE VELLE	
0	th. : After s funer	를 음	1 Natural 5 Pendir 2 Accident Investi	9	Month, Da	iy rear)	Injury	М		k≀ Yes 2.∐l	No						
DIVISION	Attender death ector:	1 Cg	3 ☐ Suicide 6 ☐ Could	inad 200.	Place of Inj	jury - At home,	farm, stre	et, facto	ry, office			28f. Location (Street and	d Numbe	r or Rura	I Route Numbe	r,
5 3	after Dire	Certification:	4 Homicide		ouilding, et	tc. (Specify)						City or To	vn, State,)			
	spira nours neral		29a. Certifier 1 🔀 Certifyir	ng Physician: T	o the best	of my knowled	ige, death	occurred	at the tim	ne, date an	d place, a	and due to the	cause(s)	and mar	nner as st	tated.	
-	24 h 24 h 8 Fui etely	Medical	(Check only 2 Medical one)	Examiner: On I	the basis o	of examination	and/or inv	estigatio	n, in my o	pinion, dea	th occurr	ed at the time,	date and	place, a	nd due to	the cause(s)	
1	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Me	29b. Signature and title of certifie					29	c. License	e number			29d. Dat	e signed	(Month,	Day, Year)	
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	6		11011		-	do 200 //	- \ C	Dallari	D003	,,,,,,			Augus	st 23	, 200		
			30. Name and address of person						#200	01	77 M	warl and O	2022				
			Philip G. Henjum 31. Date filed (Month, Day, Year)		32 Angistr	rar's Signature				, orne	:у, ма	ryrand 2	J032				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O **Physician** Blankenheimer 2007 Rosalind /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockvile Hebrew Home of Greater Washington Mongtomery If Under 24 Hrs. 8. Date of Birth Hours Min. Jan, 14, Birthplace (State or Foreign Country)
 New York **Funeral** Days Months 1 ☐ M 2 🔯 F 84 092-16-3723 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Y∏Yes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 20906 B210 North Leisure World Blvd #811 United States or Items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Insurance other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mental I Bertha Elwer Abraham Drescher ೨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Bernard Blankenheimer - Husband 3210 North Leisure World Blvd #811 Silver Spring MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 Burial 2 □ Cremation 3 Removal from State King David Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 8/26/2007 Falls Church, VA 21. Signature of Funeral Service License 22. Name and Address of Facility Edward Sagel Funeral Direction Inc. 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ZHEL FARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, the sequentially list conditions, the sequential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes Hospital or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 | Residence 6 | Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Natural Injury 1 Yes 2 No 2 Accident the Funeral Director: noletely filled in by the Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only within 24 onel 29c. License number 29d. Date signed (Month, Day, Year) 2 ٥ 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6105 ONTROSE 31. Date filed (Month, Day, Year, State 27 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2:10 PM HINGER HAVARD 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 202 Glenn Street Allegany Frostburg If Under 1 Year Date of Birth (Month, Day, Year) 5 18 23 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 213 20 7273 1 MM 2□F 84 Hours Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic even. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Allegany Maryland Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 Glenn Street U.S.A. Funeral 21532-12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Nyes 2 No If Yes, Give Year or Dates: WW I 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ģ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) machinist tire manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Samuel Bittinger Clara Ellen Burkholder 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Loy daughter Maryland 21532-Frostburg 1 Washington Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park Frostburg Maryland August 24, 2007 21. Signature of Funeral Service Licen-22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Prof. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIAC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PD > loyes Sequentially list conditions Examiner if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events the death certificate be executed use as the burial-transi and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 \sum Nursing Home 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

3

State Registrar 29b. Signature and title of certifie

george

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year) AUG 23

DHMH 17 Rev 1/2001

MD

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Migdalia Baerga-Buffler State of Maryland / Department of Health and Mental Hygiene 2007 29012 1- For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day August 22, 2007 Year 0616 hrs Medical Examiner Migdalia Baerga-Buffler c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's 7302 Westwind Court 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Rico Director Months Days Hours CountryPuerto M 2 ³ F 158-62-9581 43 Yrs 04-10-1964 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No Bowie 28a-f show Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20715 7302 Westwind Court ö Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 % Married or ite 2 * Yes Pages 1 and 2 should be filed within 72 hours after nent of Heakth and Mental Hygiene. If Yes. Give Year 18 Yes 2 No specify: Puerto Rican Specify: Puerto Rican 3 Widowed 4 Divorced "natural" ρ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than " 21215-0036 Federal Government +0.5Probation Administrator 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Juanita Velazquez marked Be Daniel Baerga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is m imatic M Bowie, MD 20715 7302 Westwind Court Cornelius M. Buffler/husband item . 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) t: If i Burial 2 Cremation 3 08-30-2007 Important: injury or otl Cedar Hill Cemetery Maryland Suitland. Donation 5 Other Specify. permit. 22. Name and Address of Facility Signature of Funeral Service Licens MD 20746 Cedar Hill FH 4111 PA Ave. Suitland, Approximate Interval Pan I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death Contact Gunshot Wound of Head Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical physician a UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ σ. Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✔ Yes 2 No 1 🗸 Yes Nο To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) **Division of Vital** Be Hospital: 1 Other: ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient this 1 Yes After 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Aug 22, 2007 Subject shot self Natural 0000 hrs Yes 2 V No 24 hours after death. Director: d in by the f Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 7302 Westwind Court, Bowie, MD (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 23, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Da 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ric Bowie	State of Maryland / Department of State of Maryland / Department of Certificate of Registrar		Reg. No. 2007 2901
Physician ledical Examine	Decedent's Name (First, Middle,Last)		Date of Death Month Day August 25, 2007 3. Time of Death 0304 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death Prince George's
Funeral	7726 Penbrook Place 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Hyattsville If Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		rs. Months Days Hours Min.	March 8 1963 Foreign ashington
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc		10d. Inside City Limits
Aaryland 28a-f show 1 at once.	MD Prince George's Palmer	10f. Zip Code	1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once		20785	U.S.A.
r death with or items 23 must be no	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto R	
s after de ral", or inter mu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:	Specify: Black
72 hours al Exan		ent's Usual Occupation (Give kind of wo most of working life. DO NOT use retire	d)
5-0036 cd within 72 hour lygiene other than "natu be Medical Exan	12th Ja	nitor	Private First, Middle, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene marked other than everut, the Medica	Rossie Bowie	Juanita	Bridges
MD 21 2 should 4 and Me 27 is ma 1 matic ev			ral Route Number, City or Town, State, Zip Code) Lmer Park, Maryland 20785
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera. In Mental Hygiera in Important: If titens 13a or 28a-f she important: If titen 37 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Eumeral Director	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or	other place)	Date 20c. Location - City or Town, State
Baltimo permit. Pag Department Important: injury or o			/2007 Washington,DC B. Jenkins Funeral Home
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter		Landover, Maryland 20785
Physician /Medical kaminer	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds	The mode of dying, saon as calculated.	Between Onset and Death
kaiiiiiei	or condition resulting in death) Due to (or as a consequence of):	14 17 9	
in a second	- Sequentially list conditions.		
recuted n and transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.		
60, ate be execut hysician and te burial - tran	UNPENDED AMENDED		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. For the Function: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transforced Control Contr	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnan	23d. Date of delivery cy Month Day Year
D.O. Box 687(that the death certifica ned by the attending ph detached for use as the	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)	
P.O. I es that the igned by the detache.		e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✔ No 3 Probably 4 Unknown
rds, P.C requires that been signed to should be detailed by			24a. Was an autopsy findings available prior to completion of cause of
of Vital Records, I mg Physician: The law requires ther this certificate has been signered director, page 2 should be not To Be Compulated.			performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rechysician: The this certificate I director, page	25. Was case referred to medical examiner?	26.Place of Death (Check of Death)	Home 5 Residence 6 ✔ Other: Scene
n of Vi			28d. Describe how injury occurred Subject shot
Division of spital or Attending hours after death. neral Director: After filled in by the func	Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be POUND. Aug 25, 2007 0230 hrs. 28e. Place of Injury - At home, farm, s		28f. Location (Street and Number or Rural Route Number, City
Div ospital o hours af meral D			or Town, State) 726 Penbrook Place, Hyattsville, Md.
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	2 2a. Certifier 1	gation, in my opinion, death occurred at	the time, date and place, and due to the cause(s)
F % F 5		29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 25, 2007
	30. Name and address of person who completed cause of death (Item 23a)		
R 3/	Donna M. Vincenti, MD Assistant Medical Examiner 1		21201
Stat Registra	a 31. Date filed (Month, Day Year) A 1 1 G 2 9 2007 A 2 32. Registrar's Signature of the		

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Physiciai /Medica	al	Decedent's Name (First, Middle, L AGNES THOMAS 4a. Facility Name (If, not institution, gi	BOWMAN				4b. City. Town	2. Date of Domesting AUG.	Day 20	Year	3. Time of Death
Examine Funeral		5. Social Security Number 6.	Rd	7. Age (In yrs	. last birthday)	If Under 1 Year	of Hunder 24	orgburg	rth mo	9 Birthola	ce (State or Foreign
Director		Usual Residence of Decedent	1□ M 2□(F		54 Yrs.	Months Days	Hours	AUG .	5, 1953		/IA, LIB.
e Maryler Ba-f ahov	cto	10a. State 10b. County MD MONTGO	MERY		FREDERIC					10d	I. Inside City Limits 1 Yes 2 No
23a or 22	Funeral Director	10e. Street and Number 1461 DOCKSIDE CT	Γ.			10f. Zip Code 21701			10g. Citizen of V	-	n
eli, or items Examiner m	_	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	,2 ₹ No		s Decedent of H es, specify Cuba Yes 2 No	ispanic Origir in, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)	o- 14. Rad Blad Specify	ce - American ck, White, etc	c.
I herd 2 should be lied within 72 hours enter death with the Marylend f Health and Mentel Hygiene. Them 27 is marked other than "natural", or items 23e or 28e-f ahow other traumatic event, the Madical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12.th	ducation ade completed) College (1	1-4or 5+)		nt's Usual Occup nd of work done NOT use retired	ation during most o	f working	16b. Kind of B	usiness/Indus	stry
penini. reges i end z snould be lied within Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than any injury or other fraumatic event, the Monce.	o Be C	17. Father's Name (First, Middle, Las William Thomas)					s Name <i>(First, Middle</i> Martha Bac	, Maiden Suman		
end 2 snd salth and 1 27 is m	100	19a. Informant's Name/Relationship Tyee Kennedy / S				Address <i>(Street</i> ockside		or Rural Route Numb Frederic		State, Zip Co 21701	•
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ate has been signed by the attending physician end page 2 should be detached for use as the buriel-trensit completed by Physician/Medical Examinar	- 1	23a. Part / Enter the disease, or con shock, or heart failure. List of by Immediate Cause (Final disease or condition resulting in death)		SCV	or as a conseque	3				i In	pproximate interval Between inset and Death
anding physician end use as the buriel-trensit	Calcal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		or as a conseque						
d by the atte	r ii y siciai	Part II. Other significant conditions of	ontributing to de	eath but not res	sulting in the unde	erlying cause giv	en in Part I.		tobacco use co Yes 2□ No	ntribute to th	ne cause of death
2 should	יושופונים מ							24a. Was	an autopsy ormed?	availa	autopsy findings able prior to pletion of cause ath?
	3	25. Was case referred to medical					26. Place of	1 ☐ Death (Check only			/es 2□No
After this funeral di	2	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation investigation	28a. Date of		ER/Outpatient 28b. Time of Injury	3 DOA Other	4 LI Nursi	-	dence 6 20th	er (Specify	elative's esidence
within 24 hours effer death. To the Funerel Director: Attert completely filled in by the funera Medical Certification:		3 Suicide 6 Could not b determined	e 28e. Place	of Injury - At h	oome, farm, street fy)	, factory, office			Street and Numb wn, State)	er or Rural R	Route Number,
in 24 hours he Funer pletely fill	3			sis of examina				place, and due to the occurred at the time,			
Toth	-	29b. Signature and title of certifier		mo	me	29c. License	-	8	29d. Date signe		y, Year)
2	3	0. Name and address of person who	- 11					Sprin	Park		
		1. Date filed (Month, Day, Year)	CCNG	K, n	no on	15 5,	luer	8001 m	7 m0	209	102

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUĞÜST 24,2007 BURROUGHS 5:04 a^M CATHERINE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES CHARLES COUNTY NURSING & REHAB LAPLATA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 97 11-07-1909 579-26-8748 MARÝLAND Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show sdical Examiner must be notified at 1 XYes 2 No Director CHARLES MD La Plata 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10200 La PLATA ROAD 20646 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. 9th HOMEMAKER PRIVATE is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be DUVALL MATILDA ROOME ဥ PERCY other traumatic 19a. Informant's Name/Relationship (Type. PringRAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 CATHERINE ELDER - DAUGHTER 8615 PAPS PARKWAY, La PLATA, MD 20646 permit. Pages 1 an Department of Heali Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANATOMY GIFTS REG. 8-24-07 | HANOVER, MARYLAND 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility RONALD TAYLOR, II FUNERAL HM108 W. NORTH AVE., BALTIMORE, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death (onces Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy has page 2 perform 1∐ Yes Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 1 Tyes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 5 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier No061652 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATUL KATYAL 11350 PEMBROOKE SQUARE, SUITE 30 WALDORF, MD31. Date filed (Month, 32. Registrar's Signat State AUG 29 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. N2 007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 16° 2007° ar 10:15 AM Banks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Oxon Hill Birchwood Nursing Home 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/23/1926 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 21X F 80 Washington, DC 577-30-4833 Director Usual Residence of Decedent filad within 72 hours after death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "neturel", or Itams 23a or 28e-f show Medical Examiner must be notified at DC Washington, DC Director 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 USA 716 Decatur St. NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Hygiene 100 Domestic Private other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental P Be Hines Charles Jones Mable Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 3605 Warner Ave., Hyattsville, MD James L. Banks Jr./Son tem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 = 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or Ft. Lincoln Cemetery 08/23/2007 Brentwood, Maryland `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Johnson & Jenkins Funeral Home W, Washington, DC 716 Kennedy St. NW, 23a. If it. Enter the disease, or complified ons triff cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause if n each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Alzheimers /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 TxUnknown page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 🗌 Yes 2∏ No 2**X** No 1 TYes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b, Time of 28d. Describe how injury occurred or Attending Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No after death Director: 2 Accident investigation filled in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year, 0 D0021954MD August 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward L. Mosley M.D. 10111 Wood Laurel Way, Bowie, MD 20721 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 8 2007 Registrar

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equires that the death certificate be executed equires that the attending physician and en signed by the attending physician and ould be detached for use as the burial-transit	Baltimore, Maryland 21215-0036	D
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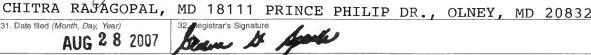
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/Medica		4a. Facility Name (If not institution, give street a	nd number)		4b. City, Town, or Lo	ocation of Death		4c. County of Deat	h	
	×	Anne Arundel Medical	Center		Annapo1	is.		Anne Aru	ndel	
Funeral Director		5. Social Security Number 6. Sex 1 M M 2	7. Age (In yrs. Ia 76	ast birthday) Yrs.		f Under 24 Hrs. 8 Hours Min.	3. Date of Birth (Month, Day, Ye 6/10/193	ar) Cc	hplace (State or Foreign untry) diana	
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r 28a	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	l ountry?	
23a o Ist be	a	104 Tarragon Lane			21037		Į	JSA		
er m	Funeral	Arn	s Decedent Ever in U.S ned Forces?	3. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Speci Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit		
xar	þ	1 ☐ Never Married 2 🛣 Married 1 🛣 1 🛣 1 1 🛣 1 1 1 1 1 1 1 1 1 1 1]Yes 2 □ No es, Give er or Dates: 1951 —			Specify:			White	
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than	Completed		lege (1-4or 5+) ears		sal Manager			Automobi	1۵	
Hygid Sther Sent, th		17. Father's Name (First, Middle, Last)	ears	Gener		8. Mother's Name (First, Middle, Maid		16	
ked c	To Be	Russell Brown			ton					
snd M	-	19a. Informant's Name/Relationship (Type. Prin	nt)	19b. Mailir	ng Address (Street and	d Number or Rural	Route Number, Ci	ty or Town, State, 2	Zip Code)	
alth a		Mary Ann Brown/ Wife		104	Tarragon I	Lane, Edg	ewater, N	MD 21037		
of He item		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Remova	from State	ace of Dispo emetery, cre	osition (Name of matory or other place)	Da	te 20c	. Location - City or	Town, State	
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Depart Import any in		21. Signatur of Funeral Meryico Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037								
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	1 live hirth 2 Fetal death 3 Ectonic prepnancy						23d. Date of de Month	livery Day Year	
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n 24 hours ne Funera pletely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: 0 an	To the best of my known the basis of examinated manner stated.	wledge, deat tion and/or in	th occurred at the time nvestigation, in my opin	, date and place, ar nion, death occurre	nd due to the caus d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)	
within 2 To the complet	Ň	29b. Signature and title of certifier			29c. License n	29c. License number 29d. Date signed (Month, Day, Yea		th, Day, Year)		
H		Kanbara Louise Blan D39497 Au						194St 20 2007		
140(30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rean Barbara L. Smit 500, 2002 Medical Pauliway Annato/18								(
Stat		31. Date filed (Month, Day, Year) AUG 2 2 2007	32. Redistrar's Signa	1000	1		J , x	-9-01		
Registra	ग्र	700 & & 2007	prome.	15.	mark!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 29018 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUG. 24 STEPHEN SLATER BOYNTON 2007 4:30P M /Medical 4a. Facility Name (If not institution, give street and number) 21036 BEALLSVILLE ROAD 4b. City, Town, or Location of Death 4c. County of Death Examiner DICKERSON MONTGOMERY 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 M 2 □ F Months Days Hours Min. 133-28-8571 70 1937 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☑ No MD MONTGOMERY DICKERSON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21036 BEALLSVILLE ROAD 20842 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CONSERVATION/ Elementary/Secondary (0-12) College (1-4or 5+) ATTORNEY WILDLIFE 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES MANSON BOYNTON MURIEL SLATER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) INGRID BOYNTON / SPOUSE 21036 BEALLSVILLE RD., DICKERSON, MD 20842 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State STAUFFER CREMATORY 8/27/07 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC NON SMALL CELL LUNG CANCER MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy performed? Yes 2 N No death? 1 ☐ Yes certificate 1∐ Yes 2 No funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home ို 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No spital or Attendliours after death.
neral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 31. Date filed (Month, Day, Year) **AUG 28** 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature, and title of certifier



29c. License number

D42452

29d. Date signed (Month, Day, Year)

AUGUST 24, 2007

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year JANET CAROL CARSON AUGUST 2007 12:01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 19830 COOL HOLLOW ROAD HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 🛛 F Director 505-50-1111 69 APRIL 21,1938 NEBRASKA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MARYLAND WASHINGTON HAGERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19830 COOL HOLLOW ROAD 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: þ 3 Widowed 4 Divorced Year or Dates: WHITECompleted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+_ TEACHER PUBLIC SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ CHRIS PETERSEN CLARA JENSEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN R. CARSON/SPOUSE 19830 COOL HOLLOW ROAD, HAGERSTOWN, MARYLAND 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗆 Burial 2 Cremation 3☐Removal from State 5 ☐ Other (Specify) 4 ☐ Donation SMITHSBURG CREMATORY 8/29/2007 SMITHSBURG, MARYLAND 21. Signature of Funeral Service Lic 22. Name and Address of Facility
BAST FUNERAL HOME 7606 Old National Pike Paul m. Dean Boonsboro, Maryland 21713 23a. P. rt1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) oncrech'e /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or muny that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 41667 8.29.07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Compos Hejerchoun Mclor mack 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 20,200 lliam Thomas Co /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore tmare 7 Year If Under 24 Hrs. 9. Birthplace Country) rs. last birthday **Funeral** Days 1 XM 2 ☐ F 220-28-4612 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1XYes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21217 Race - American India Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed intrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Magdalene Ihompson lhamas uashua 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 Is any injury or other trau Phyllis Eileen Elliott/Niece 20a. Method of Disposition | 201 821 Pine Street Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State Rethel Cemeter Aug. 25,2007 Cambridge, MO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses mD 21613 23a. Part1. Enter the disease, or complications that caused the doubt. Do not enter the mode of dying, shock, or heart failure. List only one caus, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a con a pence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disk to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 2□ No 3 Probably 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 / No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (4)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

m 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 29022 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:30 P M Carp August 23 2007 Gertrude /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 28 □ F Yrs. 94 August 24, 1912 Minnesota Director 533-32-5863 Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Chevy Chase 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code a or "natural", or items 23a 5630 Wisconsin Avenue 20815 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by White 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineering permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other ti any Injury or other traumatic event, the once. Stenographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Neff Anna Kaplan မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5630 Wisconsin Avenue, Chevy Chase, Maryland 20815 Judith Graf - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1K Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 8/26/2007 Olney, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi Funeral Home, Inc. الما 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, shock, or heart failure. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thanks one cause on each line. Immediate Cause (Final **Physician** Possible Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Persistent Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ner Due to (or as a consequence of): attending physician and for use as the burial-transit the death certificate be executed Exami Urosepsis that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Persistent Metabolic Acidosis IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ☐Yes 2 X No o the 9 Unknown signed by مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Diabetes Mellitus Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hypertension page 2 s has autopsy perform certificate 2 X No Chronic Atrial Fibrillation or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☒ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this al Director; After tr 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 00034726 M.D d cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete Ave. #302 Bethesda, MD 20814 8218 so onsin 31. Date filed (Month, Day, Ye AllG 2 M.D. Year) Registrar's Signature State Registrar

7:39 P.M

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 X No

Montgomery

Black, White, etc.

White

MD.

29d. Date signed (Month, Day, Year)

20877

Approximate
Interval Between
Onset and Death
4 Years

3 Months

Maryland

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Sandra 23, D. Combs August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 18613 Sandpiper Lane Gaithersburg if Under 1 Year | If Under 24 8. Date of Birth (Month, Day, Year) Feb. 26,1952 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🕱 F 55 216-64-0026 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Gaithersburg Director MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20879 United States 18613 Sandpiper Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Wrapper Giant Food Stores 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Farrar Josephine Shellman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca F. Wilkins (Daughter) 18613 Sandpiper Lane Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD Parklawn Mem. Park 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park DR. Gaithersburg, 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** Multiple Sclerosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Syndrome Sequentially list conditions, Physician/Medical Examiner attending physician and for use as the burial-tran

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, cate has been signed by page 2 should be detacl certificate To the Hospital or Attending Physician: this funeral neral Director: A

Certification: To Be Completed by

Medical

(Check only one)

29b. Signature and title of certifier

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Metabolic Syndrome Due to (or as a consequence of):	3 Months		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ▼No 9 □ Unknown	23c. if yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year		
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown		
		4a. Was an autopsy autopsy findings available prior to completion of cause of death? ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No		
25. Was case referred to medical examiner?	26. Place of Death (Che	ck only one)		
1 ☐ Yes 2 XX No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	National Specify Spec		
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury M 28c. Injury at Work? 1 Yes 2 No	escribe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At nome, farm, street, factory, office [28f, Lo	8f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifler 1 X Certifying Ph	ysician: To the best of my knowledge, death occurred at the time, date and place, and do	ue to the cause(s) and manner as stated.		

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DD0055109

State Registrar 31. Date filed (Month, Day, Year, AUG 2 7 2007



MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 4a. Facility Name (If not institution, give street and number) Cocper 2007 0010 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours Min 1 X M 2 □ F Yrs. July 8, 1946 61 215-46-1787 Colorado Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15812 Buena Vista Drive 20855 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Armed Folces: 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:1969-1971 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify Specify. White 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NABCA Systems Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jean Funk Martin W. Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15812 Buena Vista Drive, Derwood, Maryland 20855 Norma Cooper - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐Removal from State Ft. Lincoln Crematory 8/25/2007 Brentwood, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Liv 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 28a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imme THZ Cause (Final disease or condition resulting in death) Metarteta Choleangiocorci noma Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery 3 ☐Ectopic pregnancy Month Year

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: if item 27 is marked other thraitmetic

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medi-a Examiner must be notified at

Baltimore, Maryland 21215-0036

Director

Funeral

Completed

Be

၉

burial-transit and attending physician for use as the buria signed by the a director, this After 24 hours after death e Funeral Director: filled n by the

The law requires that the death certificate be executed

the Hospital or Attending Physician:

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Division or Vital Records, P.O. Box 68760.

Examine Physician/Medical 2 Completed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Barren

MD

2007

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

5 ☐ Other (specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24a. Was an

Olace

autopsy performed? 1☐ Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

	(Check only one)	2□	1
29b.	Signature and	title	o

29a. Certifier

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MDO60335

August 22,2007

29d. Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

31. Date filed (Month, Day Year) State Registrar

Medical

Prince 12111

Drive # 327

DHMH 17 Rev 1/2001

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 29025 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Dorothy Williams Conrad 2007 August 19, 2345 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 67 LaVale Boulevard LaVale Allegany If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 🛛 F Yrs Director 215-16-4382 86 08/24/1920 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director MD LaVale Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21502 67 LaVale Boulevard Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cambria Williams Emma Whetstone ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Conrad / Son 710 Montgomery Avenue, Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory ! 08/20/2007 4 □ Donation Cumberland, MD 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Licenses ada 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dumovale Frew wouth disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🗷 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ibrillation 1 ☐ Yes 2 → O 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 24a. Was an certificate has be rector, page 2 s autopsy performe To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 010 Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day Year) funeral 27 Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident 5 Pending investigation i Director: Al 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler

nde

State Registrar

5

31. Date filed (Month, Day, Year)

Huva

32. Registrar's Signature

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huma Shakil, M.D.,

2007

forest)

D46346

625 Kent Avenue, Cumberland, Maryland

August 20, 2007

Registrar

1160

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year),

31. Date filed (Month

James R. Moen, M.D.-1068 National Highway, LaVale, MD

6/1UA nocs

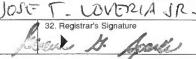
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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

State Registrar 31. Date filed (Month, Day, Year AUG 2 0 2007

29b. Signature and title of ce



HYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D50844

912 SETON DRIVE COMISERLANDMD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** VERNIG $\mathfrak{A}\mathfrak{I}$ 2001 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ROAD 9. Birthplace State or Foreign Country) 8. Date of Birth (Month, Day, Under Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) 1□M 2ØF Min 219 37 2 907 Usual Residence of Decedent Yrs. Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If tem 27 Is marked other than "natural", or items 23a or 28a-f show unt: If tem 27 Is marked other than "natural", or items 29a not 28a-f show uny or nother traumatte event, the Medical Examiner must be notified at 1 ✓Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number GUYANA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Black Specify: Be Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ 20015 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BeHSVIlle RD 7-4 MD Henr YMACE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pagi Department Important: If any Injury or 30/07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name an Address of Facility FUNDIN SENICE 20772 21. Signature of Fun Servi le License Approximate Interval Between Onset and Death 23a. Part1. Enterth disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear ailure. List only one cause on each line. Immediate Caus / nal disease or conductor resulting in dea p Physician YEARS ALZHEIMER'S /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 | Yes 2 | → Yo 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes $2\square N$ 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral of 27. Manne Death 1 1 atural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARRAGUT ALE KEYSINGTON, MD DS98

ROSENBAUM 31. Date filed (Month, Day, Year) AUG 2 9 2007

32. Registrar's Signat

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** W. Collins August Grace 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Lanham Doctor's Community Hospital Prince Georges Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 TXF Director 579-24-0144 1925 Washington, D.C. Sept.17, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Prince Georges Director Capitol Heights 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1207 Addison Rd. South 20743 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dietitian Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental k Arthur Warden Helen Mondell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 I Janice Collins/Daughter 9313 Midland Turn Upper Marlboro, Md. permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial 8/29/2007 Landover, Md. 21. Signal re of Funeral Service Fensee 22. Name and Address of Facility
Alexander S. Pope P.A.
5538 Mariboro Pike/Forestville, Md. 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ener Underly of Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physiclan and s the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: use yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1□ Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 🖳 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attending 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the Hospital within 24 hours a To the Funeral D 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

State

29c. License number D23743

29d. Date signed (Month, Day, Year)

August 23, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin Weltz, M.D. 7525 Greenway Center Dr. Greenbelt, Md. 20770

31. Date filed (Month, Day, Year)

2 9 2007



Registrar

			State of State of Registrar	Maryland / Dep <i>Ce</i>	ertificate of Dealertificate	th and Mental Hy ath	giene Reg. No. 2007	29030
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Edna Collins		_	2. Date of De Month Angus	Path Day Year Year	3. Time of Death 7 15:47 M
	Examin Funeral Director		4a. Facility Name (If not institution, give street and numb University of Maryland 5. Social Security Number 027-30-6274 Usual Residence of Decedent		/) If Under 1 Year If U		4c. County of Death N/A Th Ay, Year 1932 F10	nplace (State or Foreign unity) Orida
	Maryland f show ied at	tor	10a. State 10b. County Maryland Prince George	10c. City, Town or L	Laurel			10d. Inside City Limits 1 ☐ Yes 2 ▼No
	with the la or 28a-t be notif	Director	10e. Street and Number 9010 Briarcroft Lane		10f. Zip Code 20708		10g. Citizen of What Co	untry?
0	after death or Items 23 iminer mus	y Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes Give	XNo	Was Decedent of Hispan If Yes, specify Cuban, Mo	lic Origin? (Specify Yes or No exican, Puerto Rican, etc.) ecify:		e, etc.
0500-612	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	16a. Dece	edent's Usual Occupation re kind of work done during DO NOT use retired)	g most of working	16b. Kind of Business/	
and 21.	be filed witl tal Hygiene d other the event, the	B	12th 4yrs 17. Father's Name (First, Middle, Last)	<u> </u>		Mother's Name (First, Middle	e, Maiden Surname)	Government
Viaryia	12 should h and Men 7 Is marke traumatic	ဥ	George Edward Hodgins 19a. Informant's Name/Relationship (Type. Print) Janice Carpenter(Daugh	19b. Mail	iling Address (Street and N	aggie Burns Number or Rural Route Numb Odenton, M	ber, City or Town, State, 2	Zip Code)
more, i	Pages 1 and ent of Healt nt: If Item 2 ry or other		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from St 4 □ Donation 5 □ Other (Specify)	20b. Place of Disp	position (Warme of emailor) or other place) al Cemeter	Date	20c. Location - City or Arlington	, .
Dallimo	permit. Departm Importate any Inju		21. Signature of Funeral Service Licensee	1	MMame Reverse of	& Mort t. Annapoli	-	
08/00,	Icate be executed Medical Examiner the burial-transit	edical Examiner	resulting in death) Due to (or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or Cause)	ch line.	nter the mode of dying, su		arrest,	Approximate Interval Between Onset and Death
O. BOX	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	in the past 12 months?	nt at time of death 5	B Ectopic pre g nancy i Other (specify)		23d. Date of del Month	ivery Day Year
cords, F.	requires that the leen signed by th hould be detache	b	Part II. Other significant conditions contributing to deal Coronary artery disease w	ith 99° lo L	-main Stem		tobacco use contribute to	100.4
Ž	The la	Completed	Upper gastrointestina End stage renal dis	d bleeding sease, o	liabetes t	ype2 1□ Yes	opsy prior to death?	utopsy findings available completion of cause of
or vital	this ald	To Be	25. Was case referred to medical examiner? □ ☐ Yes ? No Hospital: ☐ In 1	patient 2 ER/Outpatie	ient 3 DOA Other: 4	Place of Death (Check only Nursing Home 5 Res		cify)
UNISION	r Atten ter deatl irector: n by the	Certification:	1 Natural 5 □ Pending (Month 2 □ Accident investigation 3 □ Suicide 6 □ Could nicode 28e. Place of	of injury - At home, farm, s g, etc. (Specify)	Work? M 1 ☐ Yes	2 ☐ No 28f. Location	(Street and Number or Rown, State)	ural Route Number,
_	To the Hospital or Atten within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) Sertifying Physician: To the base of the base	sis of examination and/or				
	Within Within	Me	29b. Signature and title of certifier Been Mi		29c. License nur	mber ,435B18129	29d. Date signed (Mont	
(Oliv		30. Name and address of person who completed cause Dawn Beckman, MD	of death (Item 23a) (Type	e, Print)	Baltmore, M		
	Sta Regist		31. Date filed (Month, Day, Year) 32 ne	rgistrar's Signature			-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 20, 2007 3:30 A Linda Lee Capstick August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 12/23/1947 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 X F Illinois 59 308-50-0151 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 TrNo Directo Annapolis Maryland | Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1122 River Bay Rd. 21409 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 years Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Lee Harrington Mary Klein ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold B. Capstick/ Husband 1122 River Bay Rd., Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8/21/07 Kalas Crematory Edgewater, MD 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, in any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or sella noneequance of) Due to (or as a consequence of):

Physician /Medical **Examiner**

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Department of Health a Important: If item 27 is any injury or other trau once.

Physician

Funeral

Director

f show

"natural", or Items 23a or 28a-f shov idioal Examiner must be notifled at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Ite ury or other traumatic event, the Medical Examine.

Baltimore, Maryland 21215-0036

/Medical

Examine y physician and as the burial-transit Physician/Medical Completed by Be Certification: To

use as

for

ed by the a detached f

ate has been signed I page 2 should be det

certificate

After this

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

funeral director,

or Attending Physician:

the Hospital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Month

2 1 ☐ Yes 3 Probably 4 Unknown

24a. Was an autopsy perform 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes

in Daney

25. Was case referred to medical examiner? No 1 ☐ Yes 27. Manner of Death Natural

29a. Certifier

(Check only

5 Pending investigation 2 Accident 3 ☐ Suicide 4 Homicide

6 ☐ Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi

10 SUD AMBPINS MOULANT 31. Date filed (Month, Day, Year,

State Registrar

Medical

AUG 22

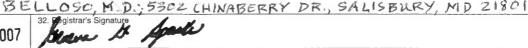
BA 6

31. Date filed (Month, Day, Year) AUG 2 7 200/

Name and ad fress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

GREGORIO M.



State Registrar

29d. Date signed (Month, Day, Year)

08-24-2007

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Hutchinson Rothwell Dennis September 1 2007 1701 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Ceci1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT 24, 192 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 X M 2 □ F Director 212-18-0096 85 1921 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 Ves 2 No Maryland Kent Galena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 109 Boxwood Lane United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 1 V Yes 2 D No. If Yes, Give Year or Dates: War II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced "natural". White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then 'eny injury or other traumatic event, the Market in Ing. Coltege (1-4or 5+) Machinist Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Dennis Clarissa Rothwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty H. Dennis/Wife 109 Boxwood Lane, Galena, Maryland 21635 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) September 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) West Chester, R.A. Ferris & Co., Inc. 3, 2007 Pennsylvania 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition **Physician** MUltisystem 24 4001 organ resulting in death) /Medical Due to (or as a consequence of): Examiner multivessel (OY one Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Ch ronce -schemec (ardio 47006 that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, sician Physician/Medical phys attending p IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 certificate ha autopsy performed? Chronic 1 ☐ Yes 2. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Dispatient this 2 ER/Outpatient 3 DOA 28a. Pate of Injury (Month, Day Year) 27. Manner of Dath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide filled in I within 24 hours a To the Funeral D Tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) repen of DO055/90 MI in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MB Unron Huspital 106 Bow Street Elkton MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 1 1 2007

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar 29034 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BULLE 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** nesapeake UTUREC +RUNDEL If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min 1□M 2▼F Hours Director 216-18-7011 83 OCTOBER 17, 1923 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL ARNOLD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a or 305 COLLEGE PARKWAY 21012 death UNITED STATES Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced 'natural', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) 'Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 Is marked other then." Elementary/Secondary (0-12) College (1-4or 5+) 6 CASHIER RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM EBLING ပ ELIZABETH SCHMIDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA PEREZ/DAUGHTER 328 NORTH LAKE ROAD, STEVENSVILLE, MARYLAND 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition AUGUST 24 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 2007 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. any 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant Por 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobação use contribute to the cause of death? Records, ð 1 Yes 2 □ No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Division of Vital 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 Inpatient Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIGHWAY MILLERSVILLE MO 21108 1, CHAEL 31. Sate filed (Month, Day, Year) 32. Registrar Signature State Registrar

07-06719

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

CTIG	icis Duii	1	- For State	Certi	ificate of	Death		Reg. N	lo	
	Physicia	_	Registrar 1. Decedent's Name (First, Middle,La	st)			15	2. Date of Death Month Da		3. Time of Death 2118 hrs
	Exami		ERIC FRANCI	S DUNNINGTON	Tal	b. City, Town, or L	ocation of Death	August 29, 20	4c. County of Death	
			4a. Facility Name (if not institution, gi SoutherCivista Medical C		"	La Plata	200411311 31 2 44		Charles	
		-	5. Social Security Number 6. 9		st birthday)	If Under 1 Year	If Under 24Hrs	8. Date of Birth (N	MM/DD/YYYY) 9. Bir	thplace (State or Foreign ountry)
	uneral irector		215-86-6512		7 Yrs.	Months Days	Hours Min	3-24-1		
	<u>\$</u>	- 001 1 77 4	Usual Residence of Decedent 10a. State 10b. County		Town or Location	on				10d. Inside City Limits
	1 0 W 31			GEORGE	KI	NG GEOR	RGE			1 X Yes 2 No
	iryland 8a-f sho at once.	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	after death with the Maryland al", or items 23a or 28a-f sho ner must be notified at once	Dire	5349 HARPER	CT. APT.#95		224			.S.A.	
0	with t ns 23s be not		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. Wa	s Decedent of His es, specify Cuban	panic Ongin? (S , Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
	death or iter must	Funeral	1 X Never Married 2 Marrie	1 Yes 2 X No					Specify: B	LACK
. 4. 4. 1 . 44.	after ral", o	by F	3 Widowed 4 Divorce 15. Decedent's Education (Specify)	led If Yes, Give Year or Dates:	16a Deceden	Yes 2 X No it's Usual Occupat	tion (Give kind of	work done 1	6b. Kind of Business	/Industry
	hour ratu Exan		Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working life	. DO NOT use re	tired)	Service of the servic	No common and the second of th
36	within 72 giene. her than "	힅	12th		LAB	ORER		Leb 1	CONSTR	UCTION
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215	uld be filed v Mental Hygi marked oth	Be	WILLIAM FRA	NCIS DUNNINGT	ON	- Address (Chr.	CATHE	RINE AND	NETTE DA er, City or Town, Sta	Y te, Zip Code)
0.21	hould nd Me is ma	2	19a. Informant's Name/Relationship							NGS, CO. 809 1
₽ Q	I and 2 shou Health and I item 27 is n r traumatic		CATHERINE DI 20a. Method of Disposition	20b.	Place of Dispos	sition (Name of ce	emetery,	Date	20c. Location - City	or Town, State
ore,	ages la nt of He nt: If its		1 X Burial 2 Cremation	3 Removal from State OA	crematory or of KLAND	ther place) CEMETE]	RY 9-	-5-07	WALDORF	,MD.
altimore,	0. 0) = 1	ph.m* 1 10 Mi	4 Donation 5 Other Spec 21. Signature of Funeral Service Lin	censee MOOA70	22.	Name and Addres	s of Facility		7 3	
Bal	permit. I Departm Importa injury o	1	me o O.	\star	/ F	SÄAMÖND	FUNER	AL SERVI	CE, P.A.	
	ysiciar		23a. Part I. Enter the disease, or co	omplications that caused the death	. Do not enter	the mode of dying	, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
	Medica	3	failure. List only one cause or Immediate Cause (Final disease	a. Narcotic and alco	ohol into	oxication				Death
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who	pa jisi	Fxamin	events resulting in death) Last	Due to (or as a consequence of	or):					
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90	e death certificate be exe the attending physician	Medi	IF FEMALE:	#23a,27,20a-1, 23c. If yes, outcome of pre	gnancy				23d. Date of deli	
387	ertifica fing p	/uc		1 Live birth Pregnant at time of d	_		Ectopic pre	gnancy	Month	Day Year
×	attenc attenc	Dhyeirian/	1 Yes 2 No 9 Unkr		leath 5	Other (Specify)				
B	the de		Part II. Other significant condition	ons contributing to death but not	resulting in the	e underlying cause	e given in Part I.			e to the cause of death?
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<u>6</u>	requir seen s	, page z snoun pe						24a. Was a autop	sy prior	e autopsy findings available to completion of cause of
ç	e has le	7 26 7 St						perfor 1 V Yes		Yes 2 No
ä	n: Th	or, pa	25. Was case referred to medical			26.Pla	ace of Death (Che			
/its	ysicial ysicial			Hospital: 1 Inpatient 2	✓ ER/Outpatie					Other:
4	ing Physic	meral	27 Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of	,	njury at Work?		how injury occurred	
2	ottendii death. ctor: /	by the fu	Natural 5 Pend 2 Accident Inves	FING 8/29/2007	7 FNd 8:	31 pm	Yes 2 X No		Street and Number of	or Rural Route Number, City
Division of Vital Records P.O.	or Attendafter death	in by	3 Suicide 6 X Could	d not be			ce building, etc.	or Town, S	state) in Hwy. LaPl	ata MD
ë	er ou	/ filled in	4 Homicide		d in mote		date and place	and due to the caus	se(s) and manner as	stated.
	he Ho in 24 } he Fu			miner: On the basis of examination	eage, aeath oc n and/or investi	igation, in my opin	nion, death occur	red at the time, date	and place, and due	to the cause(s)
	To the within	com	(Check only one) 2 Medical Example 29b. Signature and title of certifie	and manner stated.	/		ense number		29d. Date signed	(Month, Day, Year)
	,	1		1 11 //		0.	C.M.E.		August 30, 2	007
			30. Name and address of person	who completed cause of death (it	tem 23a)					
			Jack Titus MD. Der	outy Chief Medical Examir	ner 111 F	Penn Street, E	Baltimore, MI	21201		
		Sta		2007 32 Registrar's Sign	nature	artis)				
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	Registrar	o /First 181331			Ce	ertificat	e of L	veatr	1			. 21	007		
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r	4a. Facility Name (/	f not institution, g	ive street and n	umber)	_	4b. City,	Town, or	Location	of Death		4c	. County	of Death		
П		ate Driv							Hill				Harf		
	5. Social Security N		Sex 1⊠M 2□F	7. Age (In yrs.) If Under Months		If Unde Hours	Min.	8. Date of Bir (Month, Da	ay, Year))	9. Birth	place (State or ntry)	Foreig
	717-07-			92	Yrs.					Sept.	7,19	914	Per	nnsylva	nia
	Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or I	ocation								10d. Inside Cit	 y Limits
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	17. Father's Name	(First, Middle, La	st)					18. Mot	her's Nam	e (First, Middle	e, Maider	n Surnar	me)		
0		Oscar Ro	y Evans	, Sr.						Elizabe	th E	Eber.	le		
	19a. Informant's N	ame/Relationship	(Type. Print)		19b. Mai	ling Address	s (Street a	nd Num	ber or Rui	ral Ploute Numb	er, City	or Town,	, State, Zi	p Code)	
	Bonnie L	ee Evans	1		1220	Share	on Ac	res	Rd.,	Forest	: Hil	L1, 1	Maryl	Land 2	105
	20a. Method of Dis				Place of Disponentery, cr	osition (Na ematory or o	me of other place	e)		Date	20c. L	ocation -	- City or T	own, State	
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Hopewell Cemetery 08/29/07 Port Depos.											posi	t. Marv	·lar
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To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State

Registrar

State of Maryland / Department of Health and Mental Hygienes Reg. No. 2007 29038 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 12:45 pM Kenneth Elsner 2007 Allen August 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3003 Parker Avenue Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ km 2 □ F Yrs Director 213-24-3433 78 Feb. 15, 1929 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location show 10d. Inside City Limits 'natural", or Items 23a or 28a-f shov dical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3003 Parker Avenue 20902 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ☐Yes 2☐No Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Systems Analysis Government is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emanuel Elsner Rae Abramowitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Juanita Elsner/Wife 3003 Parker Avenue, Silver Spring, MD 20902 : If item? 20b. Place of Disposition (Name of cemetery, crematory or other place) August 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 2007 Alexandria, Virginia 22. Name and Address of Facilit Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, 5 MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Years /Medical Due to (or as a consequence of): Examiner Bronchiectasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Division or Vital Records, P.O. Box 68760, cal Physician/Medi by the attending partached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has b page 2 s autopsy certificate 1∐ Yes 2X No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 512 Residence 6 Other (Specify) 2X No 1 TYes 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🔀 Natural 5 Pending Injury investigation М 1 Yes 2 No 2 ☐ Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 🕦 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20388 August 24, 2007 10 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 10401 Old Georgetown Road, #104, Bethesda, MD 20814 Howard Goldstein, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State 27 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Aug 23, **Physician** 2007 Paul Easby-Smith, Jr. 3:00 pom /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brighton Gardens, Bethesda Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 DC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. 1XM 2□ F 85 Director 578-09-8279 Feb 17, 1922 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exa<u>miner must be notified at</u> 1 ☐ Yes 2X No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3514 Tarkington Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 M Yes 2 No If Yes, Give WW II Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes XX No Specify: White 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event the 4 Hardware Consultant /President Own Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Paul Easby-Smith, Sr. Catherine Rose Brodie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Easby-Smith Barnhard/Daughter 10195 Castlewood Lane, Oakton, VA 22124 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Gate of Heaven Cemetery XXBurial 2 Cremation 3 Removal from State Aug 27, 2007 Silver Spring, MD 4 □ Donation 5 □ Other (Specify) 21. Signatur Juneral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration Pneumonia 1 Day /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-trar Due to (or as a consequence of) ng physician a Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation, Congestive Heart Failure, Diabetes Mellitus-Type II 1 Tes No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1∐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b

Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

eath-Smith

31. Date filed (Month, Day, Year) 27 AUG 2007



Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** noza 0150 M Saac Tugust 2007 /Medical or Location of Death 4c. County of Death 4h City, Town 4a. Facility Name (If not institution, give Examiner 8. Date of Birth (Month, Day July 8 9. Birthplace (State or Foreign **Funeral** Days Months 41 1966 1**X** M 2 □ F Mexico none Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Baltimore 1 Yes 2 No Director None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3702 Pratt Street 21224 Mexico Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married "natural", or Specify: Mexican 1XX Yes 2□ No Specify: ð White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natu
any Injury or other traumant. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unemployed none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Candelario Espinosa Petra Cobarruvias 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ofelia Bautista/Wife 3702 Pratt Street Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State Panteon de Solidad 8/31/07 Topojaco, Mexico 4 Donation 5 Other (Specify) 21. Signatur Funeral Servi PHILIPADERINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one call see, neach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** adn months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): physician Physician/Medical the attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 1 npatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760 124 hour. the

Baltimore, Maryland 21215-0036

State Registra

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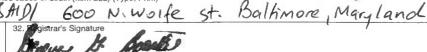
29a. Certifier

(Check only

29b. Signature and title of certifie

31. Date filed (Month, Day, Year.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

RESOCK

29d. Date signed (Month. Dav. Year)

			1- State of Maryland / Department of Health and W 1- State of Maryland / Department of Health and W 1- State of Maryland / Department of Health and W 1- State of Maryland / Department of Health and W			7 29041				
	Physici /Medic		1. Decedent's Name (First, Middle, Last) George Dewey Ford, Jr.	2. Date of Death September	er ^{Da} 2, 2007	3. Time of Death 9:15 PM M				
	Examin		4a. Facility Name (If not institution, give street and number) 2506 Coach House Way Unit 2A 4b. City, Town, or Location of Death Frederick		4c. County of Dea Frederi					
	Funeral Director		5. Social Security Number 212-24-6516 Output 6. Sex 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth Month, Day Dec 3	9. Bir 1922 M	thplace (State or Foreign ountry) aryland				
	e Maryland 3a-f show tifled at	ctor	10a. State 10b. County 10c. City, Town or Location 10c. City Town or Locati			10d. Inside City Limits 1 X Yes 2 □ No				
	th with th 23a or 24 ast be no	Funeral Director	2506 Coach House Way Unit 2A 21702	10	Og. Citizen of What Co U.S.A.	ountry?				
030	I be filed within 72 hours after death with the Maryland mal Hygiene. ed other than "natural", or Items 23a or 28a-f show e event, the Medical Examiner must be notified at	Ď	11. Marital Status 1 □ Never Married 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify: 1 □ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.				
Maryland 21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Painter/Foreman	ing	16b. Kind of Business School Bo					
anu z	e d ala	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Me e McBride	,					
	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Mrs. Barbara S. Ford, wife 19b. Mailing Address (Street and Number or Run 2506 Coach House Way,		-					
baltimore,	Page nent o ant: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	2007	20c. Location - City or Frederick	, MD				
Dall	permit. Departr Importa any Inju		21. Signature of Funcial Service Liceusee MO0255 MO0255 22. Name and Address of Facility and Basfo			e 1701				
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each ine. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	or respiratory arre	251 ,	Approximate Interval Between Onset and Death				
,00/00	tificate be executed g physician and as the burial-transit	ledical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C							
200	eath cer attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of de Month	livery Day Year				
ds, r.O.	w requires that the d been signed by the should be detached	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	oacco use contribute t es 2 → 0 3 □ P	o the cause of death?				
Vital Records,	The law req	Completed		24a. Was at autops perforr	y prior to					
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יח סר	ding Phys h. After this (funeral dir	H	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Work?	28c. Injury at Work? 28d. Describe how injury occurred						
Division or	after death after death I Director:	Certification:	2	28f. Location (St. City or Town	reet and Number or F n, State)	lural Route Number,				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.							
)	To t withi To tl	Ž		9	9d. Date signed (More September					
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre, M.D., 300 West Ninth Street, Frederic	ck, MD 21	1701					
		State Registrar SEP 1 1 2007 Registrar's Signature								

07-06784 Dennis Flowers

Amend Item 4a WCHD/SH 9/4/07 per ME Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2007 29042 10bState of Maryland / Department of Health and Mental Hygiene

mus	3 1 10	WCIS	1	Amend 40e, 10b, tate of Walland Specific of Death legistrar 10c, 10d, 10e, 10fWCHD/SH 9/24/16/24te of Death	Reg.		07 2304
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eyi-	ન્ત્ર E	xamir	ner		September	1, 2007	0658 hrs
				4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea Howard	th
				-8867 Roll Wright Court 8867 Rollright Ct. Columbia	To Date of Blath	MM/DD/YYYY) 9. B	irthplace (State or
	Fur	neral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.		Fore	ian
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	April 10 QUE / S		_ [Usual Residence of Decedent			10d. Inside City Limits
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	land	28a-f show d at once.	ō.	MD Howard Columbia	100	. Citizen of What Co	**
	Mary	28a-dat	Director	821 Washington Ave. 21/42	, , , , , ,	USA	,
<i>ک</i> م	death with the Maryland	23a or 28a-f sho notified at once.		-8867 Roll Right Ct. Apt. I 11 Marital Status	ecific Yes or No-		erican Indian, Black,
_	th wit	t be n	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	. White, etc.	
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30	50 hin 72	than dical	g	12 / Registered nurse		Medica	1
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	buld b	mar ic eve	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			
2	M 2 sho	th and		Erin Lin Flowers 8867 Roll Right Ct. A	Apt. I C	Olumbia, 20c. Location - City	or Town, State
	a and	ment of Health and Mental Hygiene. Jant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner		20a. Method of Disposition 20b. Place of Disposition (Name or cemetery, crematory or other place)	Date	200. 20041011 0119	
	mo Pages	r oth		Resthaven Cemetery 9/8	3/2007	Hagerstow	n, MD
=	Baltimore, permit Pages 1 at	Department of I Important: If injury or other		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Res 1601 Pennsylvania	sthaven	Cemetery	MD 21742
	n 5.	0 T.E		23a. Part I. Enter the disealle, or complicating that caused the death. Do not enter the mode of dying, such as cardiac of			Approximate Interval
		ician dical		failure. List only one cause on each line.	4		Between Onset and Death
		miner	1	Immediate Cause (Final disease or condition resulting in death) Hypertensive cardiovascular disease Due to (or as a consequence of):			
			1-0	h			
			ler	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		11	Miles execute
	0		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of):			
	ted	and transit		events resulting in death) Last Due to (or as a consequence of).			
	' 60, ate be executed		Medical	X UNPENDED - 4 T. 27, perME, g873, 11/2/07 TT			
	60 , ate be	physician he burial	Med	1/20d,111,27, petrus,8075, 11/2/07 11		23d. Date of deli	
	187 rtifica	ing pl	an/l	23b. Was decedent pregnant in the past 12 months?	ancy	Month	Day Year
	Box 687 e death certifie	e attending for use as t	sician/	4 Pregnant at time of death 5 Other (Specify)		1	
		by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
	P.O.	signed by I be detach	<u>\$</u>		1 Yes	2 No 3	Probably 4 🗸 Unknown
	S, l	en sig ald be	te	CLEATES	24a. Was		e autopsy findings available to completion of cause of
	aw re	has been 2 should	흩		autop	med? deat	h?
	Zec The I	certificate has ector, page 2 s	Completed	26.Place of Death (Check	1 Yes	2 No 1 V	Yes 2 No
	[5]	certifi ector,	B (25. Was case referred to medical Other; Other, Othe		Residence 6 🗸	Other: Scene
	ion of Vital Records, tending Physician: The law require	r this	10	I Innatient / ER/Outballett 3 DOA I HOLDS		now injury occurred	
	ding J	After ti funeral	l :		İ		
	Sion	death	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number of	or Rural Route Number, City
	Division	nours after d neral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, S	State)	
	- Copits	24 hours after death Funeral Director: tely filled in by the	`	1 293. Certified 1 Continue Physician: To the best of my knowledge, death occurred at the time, date and place, and	nd due to the caus	e(s) and manner as	stated.
	D the Hospital	within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	at the time, date	and place, and due	to the cause(s)
_	T _o	within 2 To the	Med	and manner stated. 29c. License number			(Month, Day, Year)
T			-	O.C.M.E.		September 1	, 2007
				30. Name and address of person who completed cause of death (Item 23a)			
4	1-2	2		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01		
			State	31. Date filed (Month Car Year) 32. Redistrar's Signature			
		Regi	ctro	31. Date filed (Month SEP 10) 5: 2007			

Funera Directo

/Medical Examiner

		1 - For State Registrar	ate of Maryland	•	artment of He rtificate of D		-	_	007	29043				
Physici /Medic		1. Decedent's Name (First, Middle, Last) William Stake	orsythe				2. Date of De Month	Day	Year 2007	3. Time of Death				
Examin		4a. Facility Name (If not institution, give stree Washington County			4b. City, Town, or Lo	ocation of Death		4c. Cou	unty of Death	nington				
uneral		5. Social Security Number 6. Sex		st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th		place (State or Foreign				
irector		2.0 2.7 7.57	^{2□ F} 78	Yrs.	Months Days	Hours Min.	Nov.30,			y land				
M #		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside City Limits				
a-f sh	tor	Maryland Washingto	on		Нало	rstown				1 □Yes 🏋No				
or 28; e not	Director	10e. Street and Number	711		10f. Zip Code	LSTOWIL		10g. Citizen	of What Cour	ntry?				
s 23a nust b		9200 Sharpsburg F				21740			USA					
lner n	Funeral	11. Marital Status 12. V 1 □ Never Married 2 Married	Vas Decedent Ever in U.S Armed Forces? (XYes 2 ☐ No 194	n- I	Was Decedent of Hisp f Yes, specify Cuban,	Mexican, Puerto	ecity Yes or No Rican, etc.)	14.1	14. Race - American Indian, Black, White, etc.					
ral", or Exam	ò		Yes, Give Year or Dates: 194		I∐Yes 2DXNo	Specify:		Spe	ecify: V	Vhite				
"natu	Completed	15. Decedent's Educatio (Specify only highest grade cor	n npleted)	16a. Deced	dent's Usual Occupati kind of work done dui DO NOT use retired)	on ring most of work	ing	16b. Kind o	Kind of Business/Industry					
than the Me	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)		rectional			Stat	te Pris	son				
other /ent, t	Be	17. Father's Name (First, Middle, Last)				8. Mother's Nam								
arked atic e	ToB	Daniel Walter For	sythe			Lottie	e Vera	Dayto	on					
7 Is m		19a. Informant's Name/Relationship (Type. F	<i>'</i>		g Address (Street and Sharpsbur			-		*				
tem 27		Nancy L. Forsythe			sition (Name of natory or other place)		Date		on - City or To					
Department or result and wenter raygener. Department or result and wenter in righter. Department if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Spenity)	wai irom State			:	+ 1 2007	Llagana		Manuland				
porta y inju		21. Signature of Funeral Service Licensee) sai	elli Rei	formed Ch. Name and Address BOOTHE FUN	of Facility eral Hon	ne. P.A.	nagers	TOWIL,	Mary Fallo				
2 = 9 9		425 S. Conococheague St. Williamsport, MD 217												
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Operating Death												
/sician ledical		Immediate Cause (Final disease or condition resulting in death) a. DEFHYDRATION AND MALNUTRITION Due to (or as a consequence of):												
aminer		Due to (or as a consequence of):												
sit	iner	Sequentially list conditions, in any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque				Z WEE							
ng physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	<u> </u>									
/sician e buria	edical E	d												
ng phy as th	Medi	IF FEMALE:												
ittendii or use	ian/M	23b. Was decedent pregnant in the past 12 months?	f yes, outcome pf pregnan □Live birth 2□Fetal	death 3	Ectopic pregnancy			23d.	Date of delive	ery Day Year				
y the a	Physici	1 Tyes 2 TNo	l∐Pregnant at time of dea ∃Unknown	ath 5∟	Other (specify)									
ned by	by Ph	Part II. Other significant conditions contribu	iting to death but not resul	ting in the ur	nderlying cause given	in Part I.	23e. Did to	obacco use o	ontribute to the	ne cause of death?				
en sig ould b		TOXIC MECHCOLO	N. CONG	3710	- CANDI BY	<u> </u>	10,	Yes 2.☐⊀N	o 3 □ Prob	oably 4 □Unknown				
asbe e2sh	Completed	FAILURE. PUL	MONNAY E	MBU	-1/DEI	USIN	24a. Was	osv .	4b. Were auto	psy findings available mpletion of cause of				
icate l			VAL PAILURE	Acui			1□ Yes		death? 1 ☐ Yes	2 □ No				
s certifi lirecto	o Be	25. Was case referred to medical examiner?	tal: 1 ☐ Inpatient 2 ☐ E	P/Outpation	t 3 DOA Other:	6. Place of Deat			011					
ter this neral d		27. Manner of Death		28b. Time of Injury		4 ☐ Nursing Ho	28d. Describe I			<i>y)</i>				
or: Af	Certification:	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(World, Day Tear)	injury		s 2 No								
Direct in by	rtifi	3 Suicide 6 Could not be 4 Homicide determined 28	Be. Place of injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tox		ımber or Rura	al Route Number,				
Training a most again. To the Funds a large location. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ledical Ce	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examination	ledge, death on and/or in	occurred at the time, vestigation, in my opir	, date and place, nion, death occur	and due to the red at the time,	cause(s) and date and pla	I manner as si	tated. o the cause(s)				
To th	Me	29b. Signature and title of certifier			29c. License n	number		29d. Date sig	gned (Month,	Day, Year)				
		Jan Melden	w		Door	01040		08-	29-2	00)				
,,,		30. Name and address of person who comple				T_05	,	2						
(+ / Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	E TAM	67 14HO	ENCRUM	wo.	4174	0					
Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu). A	Mr. Mari									

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		ľ	For State Registrar	State of	Marylan	d / Depa <i>Cel</i>	artment of <i>rtificate o</i>	Health f Deat	and N h	lental Hy	gien Reg. N	2007	29044
€.	Physici /Medi		1. Decedent's Name (First, Middle Marcia P		ı					2. Date of De 8/24/		ay Year	3. Time of Death 6:53 а м
	Examir		4a. Facility Name (If not institution 3307 Turner		nber)		4b. City, Town	or Location				County of Deat	
	Funeral Director		5. Social Security Number 191–30–4776 Usual Residence of Decedent	6. Sex 1 □ M 2 ☐ F	7. Age (In yrs. I 68	ast birthday) Yrs.	If Under 1 Ye Months Day		er 24 Hrs. Min.	8. Date of Bi (Month, Di 4/26/1	av. Year	9. Birti Co	nplace (State or Foreign untry) Pa•
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County Md. Mont 10e. Street and Number 3307 Turner 11. Marital Status 1 Never Married Marital Marital Status 1 Never Married Married (Specify only higher Elementary/Secondary (0-12) 17. Father's Name (First, Middle, David Specified) 19a. Informant's Name/Relations	Armed For 1 Yes If Yes, Giv Year or Da St grade completed St St St St St St St S	dent Ever in U.Secs? 2 No eates: 40r5+)	16a. Dece (Give life.) 19b. Mailir 330 lace of Dispo emetery, cree tional	cipal her's Nam esa her or Run ane 8/28	Public Schools ne (First, Middle, Maiden Surname) Donato ural Route Number, City or Town, State, Zip Code) Chevy Chase, Md. 20815 Date 20c. Location - City or Town, State					
8760,	Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (a. Lut Due to (c		ncer lence of):	.091 Ro	ying, such	I.E P1	KE KOCK or respiratory a	arrest,	Ie, Md.	Approximate Interval Between Onset and Death
Records, P.O. Box 68	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Completed by Physician/Medie	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🍱 No 9 ☐ Unknown Part II. Other significant condition	4□Pregna 9□Unkno	rth 2 □ Fetal ant at time of de wn	death 3	⊒Ectopic pregna ⊒Other (specify) nderlying cause		t I.	1 🗍 24a. Was	Yes 2	2 No 3 Pro	very Day Year the cause of death? obably 4 LUnknown topsy findings available completion of cause of
Vital	(0 🗀	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:				A h n n n		perfu 1□ Yes h <i>(Check only</i>	ormed? 2 X No one)		X □ No
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	28a. Date o (Month)	f Injury n, Day Year)	ER/Outpatien 28b. Time of Injury me, farm, str	f 28c. In	jury at ork?		28d. Describe	how inju	nd Number or Ru	ral Route Number,
)	To the Hospita within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the Examiner: On the ba and mann	sis of examinat	wledge, death ion and/or in	n occurred at the vestigation, in m	time, date y opinion, d	and place, eath occur	and due to the red at the time	cause(s , date ar	s) and manner as nd place, and due	stated. to the cause(s)
	Withi Con	M	29b. Signature and title of certified	3 Win	en		29c. Lice D55	nse numbe 258	7			ate signed <i>(Montl</i> 3/24/07	n, Day, Year)
			Dr. Gary		0200 o	ld Col		d. St	es. M	&N Col	.umb	ia, Md.	21046
	Sta Registr		31. Date filed (Month, Day, Year)	7 2007	gistrar's Signat	b A	mente						

State of Maryland / Department of Health and Mental Hygiene 007

Certificate of Death 29045 1 - State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Dora FREEDMAN **Physician** 2007 1:20 A August 22, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Hebrew Home of Greater Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. (Month, Day, Yea 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 ☐ M 2 💢 F 13, 1912 Russia Aug. Director 200-30-2805 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Healith and Mental Hygiene and if filem 23a or 28a-f ehow ant: if item 27 is marked other than "natural", or items 23a or 28a-f ehow ury or other traumatic event, the Medical Examinating mail tendilling at 1 Yes 2 No Maryland Montgomery Rockville **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 6121 Montrose Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ≥ ∑No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ð 3 TWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Colfege (1-4or 5+) Elementary/Secondary (0-12) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna (Unknown) Samuel Miller ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3904 Brook Meadow Lane, Olney, MD 20832 Maxine Stein, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cemetery 08/24/07 Philadelphia, PA 21. Signature of Furnara Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC Approximate fnterval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause or fmmediate Cause (Final disease or condition resulting in death) YCUTE Myo CARDIAL **Physician** /Medical Due to (or as a consequence of): Examiner ORONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine g physicien and as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. ff yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Day in the past 12 months? ō Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. <u>A</u> Division of Vital Records. 2 No 3 ☐ Probably 4 ☐ Unknown ASTIC 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**X** No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After ending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No eath. the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined To the Hospital or # e within 24 hours after e To the Funeral Dire' to 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00018084 30. Name and address of person who completed cause of death (Jym 23a) (Type, Print) MONTASE RO, ROCKVINE NO 20852 6121 MD ESH 31. Date filed (Month, Day, Year) State 2007 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 29046 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** WILLIAM RUSSELL **FENTON** August 22, 2007 5:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Months Min. Hours 1 X M 2 □ F 89 Director 212-03-1154 12-20-1917 Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3201 Nicholson Street 20782 Funeral U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 XIYes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examines once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced WWIT White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Andrew Fenton ပ္ Nannie Maude Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James L. Thomas - Nephew 4301 Floral Park Road, Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory | 08-26-2007 | Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Acute Myocardial Infarction /Medical Due to (or as a consequence of): **Examiner** Aspiration Pneumonia Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) o 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an was an autopsy performed?
Yes 2 No death? 1 ☐ Yes 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မှ 1 🔀 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? I Director: After t d in by the funera Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour. the Funeral Dir 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27660 August 23, 2007

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person we

Alpana Goswami, 31. Date filed (Month, Day, Year)
ALIG 2 9 2007

JOHON

11119 Rockville Pike, Suite G-100, Rockville, MD 20852

completed cause of death (Item 23a) (Type, Print)

MD

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 29048 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Medical Examiner KENNEDY MICHAEL FITZGERALD 2325 hrs August 18, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 26428 Arcadia Shores Rd. Easton Talbot 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director oreign Months Days Hours 589-56-0152 20 JUNE 30,1987 1 XM 2 F Country) FLORIDA Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ust be notified at once. 1 X Yes 2 No MD TALBOT EASTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26428 ARCADIA SHORES CIRCLE 21601 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Department of Health and Mehtal Eygiene. Important: If item 27 is marked other than "natural", or items 2 injury or other traumatic event, the Medical Examiner must be 1 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes Widowed Yes, Give Yea 4 Divorced Yes 2X No specify: Specify: WHITE 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 72 21215-0036 Pages 1 and 2 should be filed within 2 STUDENT UNIVERSITY OF MD 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be MARGARET WALSH MATTHEW EDWIN FITZGERALD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD MATTHEW E. FITZGERALD/FATHER 26428 ARCADIA SHORES CIRCLE, EASTON, MD 21601 20a. Method of Disposition Itimore, 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 X Cremation 3 crematory or other place) Removal from State CHESAPEAKE CREMATION CTR 8/26/2007 STEVENSVILLE, MD Donation 5 Other Specify permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 Ostrash: 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line /Medical Between Onset and Thermal injuries and smoke inhalation Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED 7,28a-f, perME, g871, 9/13/07 TT attending physician or use as the burial Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 23e. Did tobacco use contribute to the cause of death? ≥ σ. Yes 2 No 3 Probably 4 ✔ Unknown Records, Completed After this certificate has been subneral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical of Vital Be 26.Place of Death (Check only one) examiner? Hospital: Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 d Director: / Natural 5 Pending 1 Yes 2 X No 8/18/2007 subject injured in house fire 2:14 am 2 X Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 26428 Arcadia Shores Rd. Easton, MD (Specify) Homicide other-residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours after death. To the Funeral Director:

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 19, 2007

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

2007

29b. Signature and title of certifie

Zabiullah Ali, M.D.

31. Date filed (Mosth, Day, Year)

State

Registrar

State of Maryland / Department of Health and Mental Hygiene 29049 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year James Morris Faddis 19, 2007 /Medical August 10:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death South River Health & Rehab Edgewater Anne Arundel 5. Social Security Number 6. Sex 1 X X 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 176-32-3407 85 July 25, 1922 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f shovedical Examiner must be notified at Director 1 ∐Yes XX No Maryland Anne Arundel Davidsonville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3435 Kings Retreat Court Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23: Funeral 21035 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian Black, White, etc. 1 **X**1**X** es 2 □ No If Yes, Give Year or Dates: 1941-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21711Vlo þ Specify: XX Widowed 4 ☐ Divorced White 1974 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Captain U.S. Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Isaiah Faddis Jane Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra Charles S. Faddis / Son 3435 Kings Retreat Court Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important; If ite any injury or ot once, 20c Location - City or Iown, State Richhill Township, 1XXBurial 2 ☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania Fairview Cemetery 8/25/2007 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atrial Fibrillation Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to him official cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dun to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transi Exami Pulmonary Fibrosis Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical Coronary Artery Disease as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Vascular Disease 1 Yes 2 No 3 Probably 4XXUnknown History of Myocardial Infarction 24a. Was an autopsy performed? 1□ Yes ※XXNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate has ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 TYes AXNo Hospital: Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1**XX**Natural 5 Pending investigation ours after death, neral Director: / filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò To the Hospital of within 24 hours af To the Funeral D 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) Rita Dhawan, M D0062534 August 20, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Dhawan 8516 Timbervalley Court Ellicott City, Maryland 21043 31. Date filed (Month, Day, Year) AUG 2 3 2007 Registrar

DHMH 17 Rev 1/2001

6:58P M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death Minutes

Year

Day

Month

August 21, 2007

1 X Yes 2 □ No

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 2007 William August 18, Constantine Gekas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours **X**□M 2□F Director March 4, 1936 PA 164-28-0490 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M. ical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Frederick Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 South Market Street 21701 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🔀 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Principal Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William G. Gekas Mary Jouloumes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Gekas - Wife 213 South Market Street Frederick MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other East Harrisburg Cemetery 1 X Burial 2 ☐ Cremation 3 X Removal from State 08/23/2007 0 4 Donation 5 Dother (Specify) Harrisburg PA 22. Name and Address of Facility Edward Sage Funeral Direction Inc. 1091 Rock ville Pike Rock ville MD 20852 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial Infarction Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the aftending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 HUNknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【X No 24a. Was an autopsy performed? res 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of confiler 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry R. Nahin MD 20528 Boland Farm Road Suite 104 Germantown MD 20876

State Registrar

31. Date filed (Month, Day, Year)

AUG 24 2007



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D44791

State of Maryland / Department of Health and Mental Hygien 2007

Certificate of Death Reg. No. 29051 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August **Physician** 2007 26 Joseph Melvin Gorman 9:00 ам /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 729 Uniontown Road Westminster 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Oct 16 1923 **2**16-12-7208 83 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 729 Uniontown Road 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene.

is marked other than "natural", or iter 1 □ Never Married 2 □ Married WII 1 ☐ Yes 2 ☐ Yo Specify: þ Specify: White 3₺Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Chief Heat Engineer Crown Cork and Seal Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi Health and Mental H Daniel Gorman Laura Jordan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trau once. 729 Uniontown Road Westminster, MD Joe Gorman/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 8/30/2007 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Liberty Church Cemetery Westminster, MD 21. Signature of Saneral Sanyi e Licens Fritts Furieral WHome and Chapel, P.A. ar 412 Washington Road Westminster, MD 21157 or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metustat 440) Car (ino ma Months disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 1 □Live birth 2 □ Fetal dea 4 □ Pregnant at time of death Month Day Year 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient P 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation Injury 1 ∏Yes 2 ∏No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 derson Jamn 2973 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar 2007

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

Division or Vital Records, P.O.

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'-06516 ergio Portillo-G	arcia	Please Type or Print in Black Indelible State of Maryland / Department of	Ink. Ensure All Copie of Health and Mental Hy	ı s Are Legibi ygiene	
argio i ortino-c	1	1- For State Certificate C	of Death	Reg. No	
Physicia edical Exami	an/	1. Decedent's Name (First, Middle, Last) Sergio Tulio Portillo G		2. Date of Death Month Day August 23, 20	
,		Facility Name (if not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park		c. County of Death Montgomery
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min. rs.	_	WDD/YYYY) 9. Birthplace (State or Foreig E 1 Salvado:
any		Usual Residence of Decedent 10a State 10b County 10c City, Town or Loc	ation		10d. Inside City Limits
<u> </u>	tor	MD Prince George's Hyatt	sville	10g. C	1 Yes 2 X No itizen of What Country?
ih the Mar 23a or 28: notified a	I Director	1809 Crosby Road	20783 Vas Decedent of Hispanic Origin? (Sp.		1 Salvador
er death wit , or items?	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	Yes, specify Cuban, Mexican, Puerto El Salv Yes 2 No specify:	Rican, etc.)	White, etc. White
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mantal Hygerian and refer to a real result of the marked other than "natural", or items 23a or 28a-f she mit. If item 27 is marked other than "natural", or items 23a or 28a-f she more traumatic event, the Medecal Examiner must be notified at once	eted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ent's Usual Occupation (Give kind of v most of working life. DO NOT use reti Installer of chen Counter T	ired)	. Kind of Business/Industry Construction
215-0036 be filed within 72 ntal Hygiene. rked other than '	Comple	9 RIC 17. Father's Name (First, Middle, Last) Rene Portillo	18.Mother's Name	e (First, Middle, Maide n Gracia	
2121 nould be f nd Mental is marke	To Be	19a. Informant's Name/Relationship (Type, Print) Fiancee/	ling Address (Street and Number or	Rural Route Number,	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Fleah and Nental Hygene Important: I friem 27 is marked other the Injury or other traumatic event, the Med		Reyna Elizabeth Ramifez/ 100 20a. Method of Disposition 1 XBurial 2 Cremation 3 X Removal from State crematory or	0 /	Date 20	c. Location - City or Town, State San Juan Morazan, El Salvador
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Sperify: San Jua 21. Signapure of Funeral Service Licensee 22	Name and Address of Facility	OI FUNERA	AL SERVICE, P.A.
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	3241 Columbia F or the mode of dying, such as cardiac of	BIVO SILV or respiratory arrest,	ver Spring, Md20910 shock, or heart Approximate Interval Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death) a. Hemopericardium Due to (or as a consequence of): b. Due to Dissecting Aortic Aneurys	sm -	7.3(1)	
	miner	Sequentially list conditions,			
xecuted 1 and - transit	Exa	events resulting in death) Last Due to (or as a consequence or).	0./15./00 mm		
ਹ ਜ਼ੋਜ਼	ı .≃		, 2/15/08 TT		23d. Date of delivery
ivision of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be exufired earth. Director, After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the burial—in by the funeral director, page 2 should be detached for use as the burial—in the page 2 should be detached for use as the burial—in the page 2 should be detached for use as the burial—in the page 2 should be detached for use as the burial—in the page 2 should be detached for use as the burial—in the page 2 should be detached for use as the burial—in the page 2 should be detached for use as the burial—in the page 2 should be detached for use as the burial—in the page 2 should be detached for use as the burial—in the page 2 should be detached for use as the burial—in the page 3 should be detached for use as the burial—in the page 3 should be detached for use as the burial—in the page 3 should be detached for use as the burial—in the page 3 should be detached for use as the burial—in the page 3 should be detached for use as the burial—in the page 3 should be detached for use as the burial—in the page 3 should be detached for use as the burial—in the page 3 should be detached for use as the burial—in the page 3 should be appeared by the page 3 should be 4 shou	sician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	Fetal death 3 Ectopic pregn Other (Specify)	nancy	Month Day Year
that the dened by the detached f	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		cco use contribute to the cause of death?
Cords, P.O. law requires that has been signed to	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
tal Recitan: The la			26.Place of Death (Check	1 Yes 2 k only one)	No 1 ✓ Yes 2 No
/ital /siclan rsiclan ris cert	o Be	examiner? Hospital: 1 Inpatient 2 V ER/Outpati	ient 3 DOA Other Nurs	<u> </u>	sidence 6 Other:
on of Vital I ading Physician: th. T. After this certifi e funeral director,	n:	27 Manner of Death 28a, Date of Injury 28b, Time	of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred
Division tal or Attendii rs after death. 'al Director; /	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	street, factory, office building, etc.	28f. Location (Stre or Town, State	et and Number or Rural Route Number, City e)
Hospi 24 hou Funer	Medical Ce		ccurred at the time, date and place, ar tigation, in my opinion, death occurred	nd due to the cause(s d at the time, date and	s) and manner as stated. d place, and due to the cause(s)
To the To the comple	Med	and manner stated. 29b. Signature and title of dertified	29c. License number O.C.M.E.	1	9d. Date signed <i>(Month, Day,Year)</i> August 23, 2007
		30. Nam and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 2	21201	
(Regi	State stra	e 31. Date filed (Month, Day, Year) 2007 32. Segistrar's Signature	bank		

		For State Registrar		Ce	ertificate of l	Death		leg. No. 2	007	2905
Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month August	Day 23	Year 2007	3. Time of beam 9:45 p
/Medi	9	Sonja N. Goet 4a. Facility Name (If not institution, give		-)	4b. City, Town, or	Location of Death			nty of Death	
Examir	ner	Holy Cross Hospita		,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	er Spring		N	ontgome	ry
Funeral		5. Social Security Number 6. Sec	7. A	ge (In yrs. last birthda			8. Date of Birtl	Year)	9. Birthp	place (State or Fore
Director		217-34-0561]M 2 K F	69 Yrs.	Months Days	riouis Will.	January 9			ct of Colum
		Usual Residence of Decedent 10a. State 10b. County		10c. City. Town or	ocation				1	I0d. Inside City Lim
shov d at	-	Toa. State Tob. County		Too. Oity, Town of						1 □ Yes 2√
28a-f otifie	Director	Maryland Montgom	ery		Silver 10f. Zip Code	Spring		10a Citizen	of What Cour	ntry?
a or	ä	10e. Street and Number	4			20001		rog. Onzen	U.S.	
ns 23 must	eral	13421 Tamarack R	oad 12. Was Deceden	t Ever in U.S. 13	. Was Decedent of H	20904 ispanic Origin? (S	pecify Yes or No-	14. F	Race - Americ	
nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2⊠ Married 3 Widowed 4 Divorced	Armed Forces 1 ☐ Yes 2 If Yes, Give Year or Dates	6?] No	If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Puert Specify:	o Rican, etc.)	E	Black, White, ecify:	etc. White
atura cal E	ed	15. Decedent's Edu	cation	16a. Dec	edent's Usual Occup	ation	1	16b. Kind o	f Business/In	dustry
in "n Medi	Completed	(Specify only highest grad	e completed) College (1-4o	(Gr life	re kind of work done DO NOT use retired	during most of wor d)	rking			
giene er the	E C	12			Accounts Co	ounselor			Bank	
al Hy lothe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Suri	name)	
Ment arked atic e		Michael George Dy	ak			France	s L. Buch	anan		
and is m		19a. Informant's Name/Relationship (Ty	pe. Print)		iling Address (Street					
ealth m 27 her tr		Ray Goetz - Spou	se		1 Tamarack I	Road, Silve	er Spring,			
nent of H int: If ite iry or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from Stat	cemetery c	position (Name of rematory or other place	i			on - City or To	
tant: jury		4 ☐ Donation 5 ☐ Other (Specify)		<u> </u>	Memorial Par		9/2007	Rocky	ville, M	iaryland
Department o Important: If any Injury or once.		21. Signature of Funeral Service Licens	elen	/~ I	22. Name and Addre lines-Rinaldi .1800 New Har	L Funeral H		er Sprin	ng, Mary	land 20904
ysician		23a Part1. Enter the disease, or compl shock, or eart failure. List only of Immedia e Cause (Final disease or condition resulting in death)	ne cause on each	ed the death. Do not e line. Cancer	nter the mode of dyir	ng, such as cardiad	c or respiratory ar	rest,		Approximate Interval Between Onset and Deat 4 months
Medical caminer	ш	resulting in deality	Due to (or a	is a consequence of):						
	ja l	Sequentially list conditions, if any, leading to immediate	b Due to (or a	is a consequence of):						
unsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Clease of figure that initiated events								
an and irial-tra		resulting in death) Last	Due to (or a	s a consequence of):						
physician and s the burial-transit	edical		d							
the attending p thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		2 ☐ Fetal death : at time of death :	B Ectopic pregnanc;	у		23d.	Date of deliv Month	ery Day Year
signed by the a		Part II. Other significant conditions co	ntributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use o	ontribute to t	the cause of death
gr	d by						1 🗆 🕆	∕es 2⊠N	o 3∏Pro	bably 4 □Unkr
s peen s	Completed						24a. Was	an 2	4b. Were auto	opsy findings avail
e has	mc dmc							rmed?	death?	ompletion of cause
certificate ector, pag		25. Was case referred to medical				26. Place of Dea	1 Yes ath (Check only o	2 No No	1 🗆 Yes	2 NO
s cer direct	To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	tient 2 ☐ ER/Outpat	ent 3 DOA Oth	or	lome 5 ☐ Resid		Other (Speci	ify)
or death. rector: After this certificate harby the funeral director, page		27. Manner of Death	28a. Date of Ir	njury 28b. Time Day Year) Injur			28d. Describe I			
r death. ector: After by the fune	atio	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	(10011111, 2	say rour,		Yes 2 □ No	-			
after de I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of i building,	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (3 City or Tox	Street and No vn, State)	umber or Rur	al Route Number,
within 24 hours after death. To the Funeral Director: After completely filled in by the funera	Medical C			st of my knowledge, de of examination and/or stated.						
vithin F o th compl	Me	29b. Signature and title of certifier	1 0 1		29c. Licens	e number		29d. Date si	gned (Month,	Day, Year)
> - 0		1 Ady	(Dile	201, toll	D54	4378		Augu	st 24, 2	2007
		30. Name and address of person who c	ompleted cause of	death (Item 23a) (Tvt	e, Print)					
		Cheryl Aylesworth,				uite 400, N	Wheaton, M	aryland	20902	
			-							

Division or Vital Records, P.O. Box 68760,

Certification: To filled in by within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59524 23,2007 umang over 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 GRACEFIELD ROAD SILVERSPRING, MD 20904 LOVEEN J. PUTHU MANIA 31. Date filed (Month, Day, gistrár's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any lnjury or other traumatic event, the Medical Examine Baltimore, Maryland 21215-0036

> **Physician** /Medical Examiner

burial-transi ed by the attending physician detached for use as the buria

Division or Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral I

8. Date of Birth Dec. 24, 1927 9. Birthplace (State or Foreign Massachusetts 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. White Specify: 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Cutler Henry Lande 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3154 Gracefield Road, #105 Silver Spring, Md. 20904 Edward M. Gregerman -husband Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Garden of Remembrance 8/26/2007 Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic Cardiomyopathy Due to (or as a consequence of): Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D24035 August 25, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugenio S. Machado, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Day

 2007^{Year}

4c. County of Death

Prince George's

	ded #19b		per fh, Allegany		Type or Prin									-	e.		
што,	03/00/0	,,	For State Registrar		State of Ma	arylan		artmen <i>rtificat</i>				ental Hy					
		- 10	Registrar 1. Decedent's Name	e (First Middle 1 a	st)			rillicat	e or i	Dealli		2. Date of De	Reg. No.	200	17	290	56
	Physici /Medic		MARIE	TTA	7	GH	4UDI	0				Month	Day	Č	ear	0745	5 M
0	Examin				e street and number)			4b. City,		r Location				County of		(
			5. Social Security N		DSPITAL 7. AQ	e (In vrs. I	last birthday		_	36R		8. Date of Bi				ace (State or F	oreian
	Funeral Director		215 10 ² Usual Residence of	1876	□M 2 X 1F	85	Yrs.	Months	Days	Hours	Min.	(Month, D	ay, Year) 27, 192		Count Mary	ry)	
	yland now at		10a. State	10b. County		10c. City	y, Town or L	ocation.							10	d. Inside City L	_imits
	e Mar Ba-f sh	Director	Maryland	Allegar	ıy	Fro	stburg							_		1	MNo
	with th	Dire	10e. Street and Nu	^{mber} 17207 Pe	orter Road, S.V	W.		10f. Zip						zen of Wha	at Count	ry?	
	feath	Funeral	11. Marital Status		12. Was Decedent	Ever in U.	S. 13.	215 Was Dece		ispanic Ori	rigin? (Spe	cify Yes or N Rican, etc.)	∪.S. <i>I</i>	14. Race -	America	ın İndian,	
ဖွ	after o	Fur	1 Never Marr	ied 2 Married	Armed Forces? 1 ☐ Yes 2 1 1 If Yes, Give	No		If Yes, spe 1 ☐ Yes		an, Mexica Specify:		Rican, etc.)		0:6	White, e		
89	hours ural",	d by	3 Widowed		Year or Dates:		160 Door	edent's Usu	,				10h Kir		White		
21215-0036	in 72 n "nat fledica	Completed		15. Decedent's Ed	ide completed)	- 1	(Give	e kind of wo DO NOT us	rk done d	durina mos	st of workii	ng	16b. KII	nd of Busir	ness/ina	ustry	
212	d with giene.	mo;	Elementary/Second 12	ondary (0-12)	College (1-4or 5	o+)	food	services					boar	d of ed	lucatio	on	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has been than "natural", or Items 23a or 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name)							(First, Middle lenzano	e, Maiden	Surname)			
Mary	nd 2 shou Ith and N 27 Is ma		19a. Informant's N	ame/Relationship (Type. Print) sister		19b Mail 1721	ing Address 1 Por 7 Porter	(Street	and Numb Road,	er or Rura S.W	Frostbu	ber, City o	r Town, St. Marylar	ate, Zip nd	Code) 21532-	
	es 1 ar of Hea of Item 2		20a. Method of Dis	position		20b. P	Place of Disp				D	ate		cation - Ci	ty or To	vn, State	
ii.	Pages ment of I ant: If Ite ury or of			☐ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State y)		nt Micha	_			Augus	t 30, 2007	Frost	burg	Mar	yland	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Fu	uneral Service Licer	1500	1	2	22. Name ar			,	rost Ave.	Frost	huro M	/ID 2	1532	
			23a. Parti. Enter t	the disease, or com	plications that caused	the death	h. Do not er							- Care, 11		Approximate Interval Between	
	Physician	8 7	Immediate Cause disease or condition	(Final	one cause on each ling. Hyperten:		arter	occle	roti	c has	ert d	isease				Onset and Dea	ath
	/Medical		resulting in death)		Due to (or as			OBCIC		C IICO	ALC Q	130430				אשם ב	<u> </u>
- 8	Examiner	Ŀ	Sequentially list co	onditions,	b. Due to (or as	a conse u	uence of										
	uted J ansit	Examine	Sequentially list co cause. Enter Unde Cause (Disease or that initiated events	erlying injury			po 1100 015										
o,	be executed cian and burial-transit		resulting in death)		Due to (or as	a consequ	uence of):				,-						
876	ficate be physici s the bu	dical			_d						-		Sail	Num	m = 4	427,200	7
9 ×	eath certific attending p	/Med	IF FEMALE:		23c. If yes, outcome	of pregna	ancv						,	23d. Date (Š.	
P.O. Box 68760,	death e atter d for u	Physician/Medical	in the past 12	months?	1□Live birth 4□Pregnant at	2 Feta	I death 3	□Ectopic p	egnancy ec <i>ify)</i>	<i>y</i>				Month		Day Yea	ar
P.0	at the de	Phys	9 ☐ Unknown		9□Unknown												
Division or Vital Records,	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by	hip fra		contributing to death b	ut not rest	uiting in the i	underlying c	ause giv	en in Part i	1.					e cause of dea ably 4 □Unk	
lo Se	aw rec is beel 2 shou	plete										24a. Wa		24b. We	ere autor	osy findings ava	ailable
<u>~</u>	The law cate has	Completed								_		peri	opsy formed? 2 No	dea	ath?	npletion of caus 2 ☐ No	se or
Vita	Iclan: certific ector,	Be	25. Was case reference examiner?		Hospital:				Oth	0.51		(Check only					
ō	Physician: The rthis certificate is rail director, page	- To	Yes 2□ 27. Manner of Dear		28a. Date of Inju	ıry	ER/Outpatie			4 🗆 NI		me 5 Res 28d. Describe				')	
ion	ath. rr: After i	ation	1 Natural 2 Accident	5 ☐ Pending investigation	Month, Da	y Year)	203	Ом	8c. Injur Wor 1 □	k? Yes ≩ ⊈	,	PT FELL					
ivis	To the Hospital or Attend within 24 hours after death. To the Funeral Director: v	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ury - At ho c. <i>(Specif</i>)	ome, farm, s	treet, factor	, office		2	28f. Location City or To	own, State)	,	Route Numbe	
	spital ours at leral Dieral Di		29a. Certifier	1 X Certifying Ph	nysician: To the best	of my kno	-	ath occurred	at the tir	me, date a		17207	POPTE e cause(s)			ated	L
	ne Hos n 24 h ne Fur oletely	Medical	(Check only one)	2 ☐ Medical Exam	miner: On the basis o and manner sta	f examina	tion and/or i	investigation	, in my c	ppinion, de	ath occurr	ed at the time	e, date and	d place, an	d due to	the cause(s)	
	To th To th Com	Ň	29b. Signature and				^	290		e number	- /		^	te signed (- 7
	10			Man	Farm	m	υ	I	> 2	54	06		14 M	6 WS	T	27,20	10+
	nds		30. Name and add	ress of person who	completed cause of d	leath (Item	Seton	Print)	e	Cu	mh	erlan	d. 1	nD	213	502	
	Sta		31. Date filed (Mor	nth, Day, Year)	32. R str	ar's Signa	ture	hazet.	,				- / /				
	Registr	ar		AUG 28	2007		10 /										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 Martha I. Green August 0015 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medica1 Center Anne Arundel Annapolis If Under 24 Hrs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 □ M 2 💢 F Director 213-36-0085 27 Nov 1935 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notifiled at 1X Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Arbor Hill Rd. 21403 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: Specify: Black 2 3 Widowed 4 Divorced Completed is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Crownsville College (1-4or 5+) Elementary/Secondary (0-12) State Hospital Custodian 9th 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev James Green Ellen Hopkins ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Collins(Daughter) Melrob Ct. Apt Tl Annapolis, Md. 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Chews UM Church 8-25-07 West River, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Williame Reddes of Sacilisons Mortuary, P.A. 821 West St. Annapolis, Md. 1400483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner eto quelosici Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-tran and Due to (or as a consequence of): physician Physician/Medical the attending phase as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ № 0 has certificate | 1∐ Yes 2 NO 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 1 Tes 2 1 patient 2 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation M within 24 hours after death

To the Funeral Director:
cpmpletely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Telestifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

requires that the death certificate be executed Box 68760, P.O. Division or Vital Records, or Attending

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

death.

Hospital

State Registrar

31. Date filed (Month, Day, Year) AUG 2 3 2007

29b. Signature and file of certifier

(Check only one)

> 32. gistrar's Signature

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

200

8/2

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Patricia Barbara Harbold September 3, 2007 1:22 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F **72** Sept. 25,1934 Pennsylvania 167-30-5191 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medi-al Examiner must be notified at 1 TYes XXNo **Funeral Director** Maryland St. Mary's Mechanicsville 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number filed within 72 hours after death with 20659 USA 35696 Golf Course Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 □ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Doctors Office** 12 Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 Michael 1 Dwyer Clara Dwyer ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 35696 Golf Course Drive, Mechanicsville, MD 20659 Curvin L. Harbold/Spouse Department of Heall Important: If Item 2 any injury or other once. other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/07/2007 Dillsburg, PA Dillsburg Cemetery 2. Name and Address of Facility
Brinsfield—Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, MD 20622 21. Signature of Funeral Service License M00817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cubles arch, Haura /Medical Due to (or as a consequence of): Examiner myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examiner burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the for use as IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Obstractive palmony disease autopsy performed Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25€No 2 ►ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 4 hours after death. Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Directory filled in by 4 ☐ Homicide TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier

State Registrar

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25500 20 32 Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and add bas of person who completed cause of death (Item 23a) (Type, Print)

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Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a To the Funeral I

32. Registrar's Signature

and manner stated

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State Registrar

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Registrar

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State of Maryland / Department of Health and Mental Hygien 2 1 7 29061 Certificate of Death Reg. No 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Annette С. Halpern 21, 2007 August 2:00 P. M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 New York 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🖼 F 089-52-2593 89 Yrs. Director Jan. 6, 1918 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits *ohe 10a. State 10b. County r then "natural", or Items 23a or 28a-f ehov The Medical Examiner must be notified at 1∏Yes 2∏No Be Completed by Funeral Director Maryland Montgomery Rockville 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 6121 Montrose Road 20852 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8th Grade Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If Item 27 Is marked other? other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Austern Nathan Halpern 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 4101 Leland Street, Chevy Chase, Maryland Norman A. Luban - Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State ŏ permit. Page Department of Important: If any Injury or Metropolitan Crematory 8/23/07 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 week manition /Medical Due to (or as a consequence of): Examiner dysohania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) should be detached 1 ☐ Yes 2 ☑ No of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 PNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? erdoral Dalsa 2 No 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel Completely filled 1 [V Certifying Physician: To the best of my knowledge ideath occurred at the time, date and place and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print MD Mantrose 6121 State 2007 Registrar

Amnette Halpern

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:32 A_M AUGUST 24 2007 ANGELA MARIE HASTINGS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location ol Death Examiner QUEEN ANNE'S 215 QUEEN ANNE ROAD STEVENSVILLE Il Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 X F Yrs. 1912 94 OCTOBER 8, PENNSYLVANIA Director 202-03-3900 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other then "nature!", or iteme 23a or 28a-f eho vent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director **QUEEN ANNE'S** MARYLAND STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 215 QUEEN ANNE ROAD 21666 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ... Pages 1 and 2 should be fill iment of Health and Mental H tant: If Item 27 is marked ott jury or other traumatic ever Be UNKNOWN 2 UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 154 BAY DRIVE, STEVENSVILLE, MARYLAND 21666 JOAN OLIVER/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition AUGUST 28 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny injury or page. 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 2007 SILVER SPRING, MARYLAND 21. Signature of Euneral Sovice Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COLON CANCER WITH METASTASIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed inding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 KNo Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ **ALZHEIMERS** 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy lindings available prior to completion of cause of death?

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1 Yes 2 No 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours after c 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 24 ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 allsa D27055 AUGUST 24, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOEL WILKERSON, M.D. 205 MEDICAL CENTER ROAD, GRASONVILLE, MARYLAND 21638 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 27 Registrar

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Baltimore permit. Pages 1 Department of the Important: If injury or other		21. Signature of Fureval Service Licensee. 22) Name and Address of Facility Home and Chapel, P.A. 412 Washington Road Westminster, MD											D 211	57
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Division of Vital Records, P.O. tall or Attending Physician: The law requires that the safter death. **Alter this certificate has been signed by led in by the funeral director, page 2 should be detact.	by F	Part II. Other significant cond	arrous continuum	y to death but not	resulting in the	, and on you	9 54.500 2	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 🗆 🗅	res 2 🗸 No	3 Pr	obably 4	Unknown
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trar	Medical	2 🖳	and manne	er stated.	r and/or nivesti			se number					Month, Day,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Albert Wilbert Harmon 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | 2 | 11 | 15 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 217-28-4586 74 Yrs Director 1933 Kent Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Director Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 7413 Poplar Ave USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 'natural", or Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Š 3 Widowed 4 Divorced Completed f Health and Mental Hygiene.
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Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Chestertown, Janes U.M. 4 ☐ Donation 5 ☐ Other (Specify) MD 9/5/07 22. Name and Address of Facility Kenneth Walley Funeral Service 821 W. St. Annapolis, MD 21401 ture of Funeral Service License (W00026) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has b rector, page 2 s autopsy performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of exa nation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. Ligegse number 30 / 29b. Signature and title of certifier (Item 23a) (Type, Print) 30. Name and address of person who READ STES CHESTEN POUNT MD

State Registrar

DHMH 17 Rev 1/2001

ar's Signature

State of Manyland / Department of Health and Mental Hygienes o o

		3	tate of Maryland	Certificate of	Death		1. No.	29065			
	Dhamisias	1. Decedent's Name (First, Middle, Last)			2	. Dete of Deeth Month	Dey Year	3. Time of Death			
	Physician /Medical	Labonya Prova Hal	der			August	24, 2007	10:00 p.m			
	Examiner	4a Fecility Name (If not institution, give street	et and number)		4b. City, Town, or Loca	tion of Deeth	4c. County of Deeth	i			
Ī	Funeral Director	217-70-3476	2K F 7. Age (In yrs. le	st birthday) If Under 1 Yea Months Deys		e Date of Birth (Month, Day, Y ebruary		George's nplace (State or Foreign untry) India			
	pue *	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City,	Town or Location				10d. Inside City Limits			
	f sho	Maryland Prince Ge		Hyattsville				1 ☐ Yes 2 ☑ No			
	rec	10e. Street end Number	orge b	10f. Zip Code		100	. Citizen of What Cou	untry?			
	h with	4410 Oglethorpe St	reet	207	81		USA				
21215-0020	filed within 72 hours after death with the Meryland Hygiam. Hygiam. Hygiam ther than "natural; or terms 23s or 28s-f show ent, the Mexical Examiner must be notified at e Completed by Funeral Director.	1 ☐ Never Merried 2 ☑ Married	Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2000No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Speci ban, Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - Amer Black, White Specilasian				
2-0	72 ho	15. Decedent's Educetic (Specify only highest grade co	on mpleted)	16e. Decedent's Usuel Occu	upation e during most of working ed)	16	ndustry				
121	led within 72 hours a lygiena. her than "natural", of it, the Manical Exart Completed by		College (1-4or 5+)		ed)						
2	Per the	17. Fether's Name (First, Middle, Last)		Homemaker	18. Mother's Name (i	First, Middle, Ma	Own Ho	ome			
Maryland	d be fill inter H ed off	Saroj Kumar Chatte	riee		Padma R.						
2	should han he marked marked marked	19a. Informant's Name/Relationship (Type,		19b. Mailing Address (Stree				ip Code)			
Baltimore, Ma	permit. Peges 1 and 2 should be filed within 72 hours after death with the Menylan Deperment of Health and Manlel Hygiena. Deperment of Health and Manlel Hygiena. Important: If them 27 is marked other than *natural; or theme 23a or 28a-f show any injury or other traumatic event, the Mexical Examiner mant be notified at once. To Be Completed by Funeral Director	Derek Halder/Son 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	20b. Pla cel	4410 Oglethor ace of Disposition (Name of metery, crematory or other pl	ace) Au	Date 28	oc. Location - City or 1	Town, State			
	it. Pertman	4 Donation 5 Other (Specify) George Washington Cemetery 2007 Adelphi, M 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility									
Ba	Deperiment in the periment in	23a. Pert1. Enter the disease, or complication shock, of heart failure. List only one complexes the complexe of the complexe o	John	Francis J 500 Unive	. Collins F rsity Blvd,	W., Si	lver_Sprin	ng, MD 20901			
68760,	asth certificate be executed attending physician and for use as the burial-transit clan/Medical Examiner	resulting in death)	Multiple Mye Due to (or	es a consequence of):				More than 1 week			
Box	ath ce	- u									
o ·	of the death cert d by the attandin etached for use Physician/N	Part II. Other significant conditions contrib			given in Part I.			to the cause of death?			
0.		Diabetes Mellitus,	nypertension			1 Yes	8 2 □ No 3 □ Pr	obably 4 Unknown			
Records,	 The law requires thet the death certaile has been signed by the attendin page 2 should be detached for use Completed by Physician/N 					24a. Was an perlorm	ed?	Were autopsy findings available prior to completion of cause of death?			
¥	The law the has bege 2					1 □ Yes	20010	1 ☐ Yes 2 ☐ No			
	ician: The certificate rector, peg	25. Was case referred to medical examiner?			26. Place of Death (Check only one)				
<u>></u>	Physic this ce ral dire	1 ☐ Yes 2 No	1 Inpatient 2 LE	EN/Outpatient 3LJ DOA			ce 6 Other (Spec	oify)			
Division of		1 Natural 5 Pending investigation	Rea. Date of Injury (Month, Dey Year)	28b. Time of 28c. Inj Injury M 1[uryat 28 ork? □Yes 2□No	d. Describe hov	v injury occurred				
DIVIS	s efter de s efter de si Directo ad in by t	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory, office	e 28	f, Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,			
)	To the Hospital or Attending F within 24 hours stear death to the Funeral Director: After completely filled in by the funer Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physicial 2 Medical Examiner:	nn: To the best of my know On the basis of examinetic end manner steted.	rledge, death occurred at the on end/or investigation, in my	time, date and place, en opinion, death occurred	d due to the cat l et the time, dat	use(s) and manner es te and place, and due	stated. to the cause(s)			
_	Within To the comp	29b. Signature and title of certifier	nse number	29	d. Date signed (Monti	h, Dey, Year)					
	1	Kaman	K Th	J. 127	4609	>	5.24-6	3/			
	T	30. Name end address of person who compi Raman Tuli, MD 3	leted cause of deeth (Item 503 Perry St	23e)(Type, Print) reet, Mt. Rai	nier, MD 20	712					
7	State Registrar	31. Dete filed (Month, Day, Year) AUG 27 200	32. Registrer's Signet	y freeli							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** pM Michael Halder August 24, 2007 5:01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Clinton Prince George's 5. Social Security Number Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday, **Funeral** 220-78-2803 Days Hours 53 tx M 2 ☐ F Director Nov. 9, India 1953 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show rai", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4410 Oglethorpe Street, Apt. 109 20781 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 21 ☑ No Specify: ρ ^{Specify} Asian Indian "natural", 3 ☐ Widowed 4 TDivorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer General Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Probodh K. Halder Labonya Chatterjee ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derek Halder/Brother 4410 Oglethorpe Street, Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 28. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington 4 ☐ Donation 5 ☐ Other (Specify) 2007 Adelphi, Maryland Cemetery
22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Deter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) /lecomonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Exam resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ No No 1 □ Yes 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy certificate 1∐ Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Division or Vital Records, P.O. Box 68760, Physician: To the Hospital or Attending

Baltimore, Maryland 21215-0036

State Registra 29b. Signature

within 2

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DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 27 2007 AUG

certifier

Richard Palmer MD

Suite 310, Washington, 1328 Southern avenue 18

and manner stated.

MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrar Ameno#'s 20a 1. Decedent's Name (First, Middle, L		8-07crCe	rtificate of I	Death	2. Date of De	Reg. No		3. Time of Death	
	Physici		Michael Dam:	-				August	24,	2007 Year	4:48 P	М
	/Medic Examir		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death		-	. County of Death		
gli	LAUTIII		Prince Georges' Com	unity Hospital		Chever	:ly			P.G.		
-41	Funeral Director		214-02-7350	Sex 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 10/18/1	rth ay, Year 1980	9. Birth Cou Wash	place (State or Fore intry) ington, D.C.	_
	and		Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or Lo	cation					10d. Inside City Lim	iits
	Maryl f sho	ō	MD PG		Riverdale	2					1 ∑ Yes 2□	No
	28a-	rect	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Cou	intry?	
	3a of	Funeral Director	6153 64th Avenue			20737	7			U.S.A.		
	death ms 2	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or N	0-	14. Race - Amer Black, White	ican Indian,	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, them "stem 27 is marked other than "natural", or items 23e or 28e-1 show other traumatic event, the Modical Exeminar marker colling and other traumatic event, the Modical Exeminar marker colling and	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:	Tiloan, etc.)		Specify: Bla		
5-0	72 h	etec	15. Decedent's (Specify only highest of		(Give	dent's Usual Occup	during most of works	ing	16b. i	Kind of Business/Ir	ndustry	
121	han ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	1)			- ' '		
	filled v Hygie other t		17. Father's Name (First, Middle, La.	2 years	Tran	sport Cars	18. Mother's Name	a (First Middle	A Maide	Private		
Maryland	2 should be filled withir and Mental Hygiene. is marked other than aumatic event, the M.	To Be	Ronald Edwards				Karen H	ławkins				
Nar	12 sh h and 7 is m		19a. Informant's Name/Relationship Karen Johnson - Moth			•	and Number or Aura Riverdale		-		p Coae)	
	Health Health tem 27		20a. Method of Disposition	205	Place of Diese	nition /Alama of	Г	Date		ocation - City or T	own, State	
Baltimore,	Page nent c ant: If ary or		1 → Burial 2 🕅 Cremation 3 `4 □ Donation 5 □ Other (Spec	Removal from State	cemetery, crei	natory or other plac	ory 09/03	72007 720 07	West Be	r ington, D.	e. Md.	
Balt	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service Lic		22	2. Name and Addre		eman Fun	eral aryla	Services and 20748		
12.0			23a. Part Enter the disease, or co shock, or heart failure. List on	mplications that caused the de	eath. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory	arrest,		Approximate Interval Between	
I	Physician		Immediate Cause (Final disease or condition	FATAI /	ARDIAC.	ARRHY	HHM/A				Onset and Death	
	/Medical		resulting in death)	Due to (or as a cons	equence of):	ARRHY ZANCER						
в	Examiner		Sequentially list conditions	METASTAT	TIC (ANCER						
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68760,	rificate be executed og physician and as the burial-transit	Medical		d								_
	ding p		IF FEMALE:	23c. If yes, outcome of preg	nancy					23d. Date of deliv	/OD/	
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	that ned b		Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	7
ds.	uires sigr	d by						1 🗆	Yes 2	2□No 3□Pro	bably 4 Unkno	wn
Records,	- Q 77	Completed						24a. Wa		24b. Were au	opsy findings availa	ple
Re	The law ate has bage 2 a	шо						auto peri 1 Yes	opsy formed?	prior to c death?	topsy findings availa ompletion of cause 2 No	Of
Vital	sician: Th certificate rector, pag	a)	25. Was case referred to medical				26. Place of Deatl		- ' '	10,103	20110	_
<u>></u>	Physician: The Ithis certificate har director, page	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2	⊠ ER/Outpatier	nt 3 DOA Oth	00			6 ☐Other (Spec	sify)	
of	ਦੂ ≑ੁਫ਼		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe	how inj	ury occurred		
ior	Attending r death. ector: After you the fune	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	ion	,,		Yes 2 □ No					
Division	after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		t home, farm, st ecify)	reet, factory, office		28f. Location City or To	(Street a own, Sta	and Number or Ru te)	ral Route Number,	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C		Physician: To the best of my laminer: On the basis of exam and mapper stated.								
	To the within 2 To the comple	Me	29b. Signature and title of certifier	//		29c. Licens	e number			ate signed (Month		
			1	JAIII)		2	58951			8-25	-07	
R	(2)		30. Name and address of person w	o completed cause of death (I	tem 23a) (Type,	Print) TAL DR	NE	CHEV	ERL	Y MD	-07 20785	
	Sta	ate	31. Date filed (Month, Day Year)	32. Registrar's Sig	gnature			9,01		1		
	Regist		31. Date filed (Month, Day Year) AUG 2 8 2007	Beneur D.	opera							

			For State Registrar	State of Maryla	-	artment o			ental Hy	giene Reg. No.	2007	29	068
	hysici:		1. Decedent's Name (First, Middle, Isaac Hill	Last)				A	2. Date of De Month	ath Day		3. Time of 0 7 4 0	
	/Medio Examin			ospital		Silve	vn, or Location	n of Death		4c. (County of Death	CY.	
Di	ineral rector		5. Social Security Number 579-14-7304 Usual Residence of Decedent	6. Sex 7. Age (In yrs 12XM 2□F 85	s. last birthday Yrs.		ays Hours	Min.	8. Date of Bir (Month, Da 09/07	m ly, Year) 1192	9. Birti Con	nplace (State o	unk.
e M ar ylan	3a-f show tified at	ctor	DC 10b. County		Sity, Town or L Shing							10d. Inside C	ity Limits 2 ∏ No
th with th	23a or 20 ust be no	Funeral Director	1360 Peabody	Street NW		10f. Zip Co 2001				10g. Citiz	zen of What Cou A	untry?	
5-UU.So 72 hours after death with the Maryland	f item 27 is marked other than "natural", or items 23a or 28a-f show ir other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2X Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? ad 1 Yes, Give Year or Dates:	U.S. 13.	Was Deceden If Yes, specify 1 ☐ Yes 2			cify Yes or No Rican, etc.)		14. Race - Amer Black, White Specify: B1	e, etc.	
within 72 ho	than "natur the Medica	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 1 2 t h	s Education t grade completed) College (1-4or 5+)	16a. Dece (Give life. Dri	edent's Usual C e kind of work o DO NOT use r Ver	eccupation lone during mo etired)	ost of workir	ng	I	od of Business/I	•	сy
aryland z should be filed v ind Mental Hygie	arked other atic event, t	To Be Co	17. Father's Name (First, Middle, L Unknown	ast)					(First, Middle		Surname)		
and 2 sho	n 27 is m er traum		19a. Informant's Name/Relationsh Mary Belle H.	Hill(Wife)	1255	Wisco	nsin .	Ave N	W Was	h,DO	Town, State, Z	7	
allimore mit. Pages 1 partment of Ho	Important: If Iter any Injury or oth once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from State Ri	cemetery, cre	osition (Name ematory or othe Pk	r place)		ate 3 / 0 7		erdale	Maryl	
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/Me	sician edical		23a. Part1. Ently the disease, or a shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Cardion Due to (or as a conse	lmona:	nter the mode o		as cardiac o	r respiratory a	irrest,		Approxima Interval Be Onset and	le tween Death
	miner	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. Pneumoni Due to (or as a conse			-						
ocrificate be executed	hysician and the burlal-tra		resulting in death) Last	Due to (or as a conse		ailure		-					
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ecords, P.O.	in signed by	by	Part II. Other significant conditio	ns contributing to death but not re	esulting in the	underlying caus	se given in Par	rt I.			se contribute to □ No 3 □ Pr		
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Or VITAI	nis certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Mnpatient 2	☐ ER/Outpatie	ent 3 DOA	Other:		<i>(Check only</i> me 5□Res		3 □Other (Spec	cify)	
_ ē	uffer		27. Manner of Death 1 Natural 5 Pending investig	ation	28b. Time Injury	of 28c	Injury at Work? 1 ☐ Yes 2 [28d. Describe	how injury	y occurred		
DIVISIO To the Hospital or Attendi	iral Direct	Certification:	3 Suicide 6 Could n 4 Homicide determi	building, etc. (Spe	city)				City or To	wn, State,			nber,
the Hosp in 24 hou	the Fune	Medical	(Check only 2 Medical sone)	g Physician: To the best of my k Examiner: On the basis of exami and manner stated.		investigation, in	my opinion, o	death occurr		, date and	l place, and due	to the cause(,s)
To	COUL	Σ	29b. Signature and title of certifier	Then	me		icense numbe 55069	er	Ĭ.		st 20,		
2 (7)		30. Name and address of person of Sirak Lemma M	D 1500 Fores	t Gler	n RD S	ilver	Spri	ng MD	209	10		
	Sta Regista		31. Date filed (Month, Day, Year) AUG 2 8 2007	32. Registrar's Sig	nature								

DHMH 17 Rev 1/2001

Registrar

		1 = For State Registrar Amend	items 25,	27,28a-1	peren	ficate of C	120/070	ihb	Reg. No.	07 29070	
Dhami		Decedent's Name (First, Middle, Last)						2, Date of De Month	ath Day	3. Time of Death	
Physic /Med		Susan Hastings							19. 2007 2.13 M		
Exam		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or L	Location of Deat			ty of Death	
		Holy Cross Hospital				Silver S	~~d~~~		Monto	omerv	
Funera	1		6. Sex	7. Age (In yrs. la		If Under 1 Year	If Under 24 Hrs			9. Birthplece (State or Foreign	
Directo		219-74-7953	1 ☐ M 2 🗓 F	65	Yrs.	Months Days	Hours Min.			Country)	
within 72 hours after death with the Maryland sne. then "natural", or Items 23e or 28e-f show the Mudical Examiner must be notified at		Usual Residence of Decedent						Sep 11, 1	941	Unknown	
		10a. State 10b. County		10c. City	, Town or Loca	tion				10d. Inside City Limits	
	ţ	MD Montgo	merv	B.	ethesda					1 □ Yes XXNo	
	Director	10e. Street and Number			ciresua	10f. Zip Code			10a. Citizen of	What Country?	
										,	
	Funeral	9317 East Park		Ve cedent Ever in U.S	2 12 W	20895 as Decedent of His		Constitution of No.	USA	ice - American Indian,	
lten Iten	5	1X Never Married 2 Marrie	Armed F	orces?		es, specify Cuban	, Mexican, Puer	to Rican, etc.)	Bi	ack, White, etc.	
s aff	by	3 Widowed 4 Divorced	If Yes, G	ive	10	∐Yes 2 X ΩNο	Specify:		Speci	ήν: White	
partitioner, Mar yiarin ZIZIO-000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23e or 28a-f show eny injury or other traumatic event, tre Medical Examiner must be notified at page.	B										
	Completed					nd of work done du	work done during most of working			Kind of Business/Industry	
	E G	Elementary/Secondary (0-12) College (1-4or 5+)					· ·				
		. <u> </u>	1	<u>_</u> i	Never	Worked					
	a a	17. Father's Name (First, Middle, L	.ast)			1	18. Mother's Nai	me (First, Middle,	, Maiden Suma	me)	
	ုင	Unknown					Unkn	nown			
		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Aura						ural Route Numbe	er, City or Town	n, State, Zip Code)	
	10.	Heaven D. Martino /	Program Ma	nager	1320 Fen	wick Lane,	Suite 30	0. Silver	Scring, I	MD 20910	
		20a. Method of Disposition		20b. Pla	ace of Disposit	ion (Name of		Date	The state of the s	- City or Town, State	
	de	1 Burial 2 □ Cremation '4 □ Donation 5 □ Other (Sp.		State		tory or other place) en Cemetery	1	5, 2007	Cilvon C	ming MD	
in in in in in in in in in in in in in i		21. Signature of Funeral Service L		odec		_	, ,			oring, MD	
Dall. permit. Departimport		D V. 51.0.	10011300		22.1	allie alla Addiess	Fra	ncis J. Co	llins Fu	neral Home Inc.	
		500 University Blvd W, Silver Spring MD 20901									
		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
Physician		Immediate Cause (Final disease or condition	7cm	ization ui	th mooni	ratory fail	1			Onset and Death	
/Medical		resulting in death)		(or as a consequ		racory rari	<u>Iure</u>		1 1870	ENT! 1 hr	
Examiner			Sev	ere mental	retarda	tion		0.	E Min	***	
	e e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						RIPLE	MER	ycarb	
cate be executed physician and the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Aspiration with respiratory failure Due to (or as a consequence of): Severe mental retardation Due to (or as a consequence of): Seizure Disorder Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last									
	Xa	resulting in death) Last	C. Due to	(or as a conseque	onsequence of):			O BY MILE	, me		
d to the cate be e	cal		l .				LICATIVE A				
phys the	Q		d			1257	1				
	Me	IF FEMALE:	22. 1/				1			1	
death certif	lan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo 9 Ultransure 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown								23d. Date of delivery Month Day Year	
be ade	U								IV	onth Daty real	
at the d by the stache	Physi	9 Unknown									
es tha	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							tribute to the cause of death?		
requir		Paroxysmal Atrial Fibrillation						1 🗆 1	res 2XXVo	3 ☐ Probably 4 ☐ Unknown	
	ompleted			*				24a. Was	24h	Wasa sutaney findings sucitable	
he law e has b	E G							autop		Were autopsy findings available prior to completion of cause of death?	
The cate had	ပိ							1 ☐ Yes		1 ☐ Yes 2 ☐ No	
		25. Was case referred to medical examiner?				2	26. Place of Dea	ath (Check only o	ne)		
cian: ertifica	Be			Inpatient 2XXE	R/Outpatient	3 DOA Other:	4 Nursing H	lome 5 ☐ Resid	dence 6 🗆 Oti	her (Specify)	
ysician: is certifica	0 8	1 ★Yes 2 No	Hospital: 1 🗆								
a this	ToB	1 ★Yes 2★No 27. Manner of Death	28a. Date	of Injury 2	28b. Time of	28c. Injury a	it	28d. Describe h	now injury occu-	rred	
ng Phy fler this ineral d	ToB	1 ★ Yes 2★ No 27. Manner of Death Thatural 5 Pending	28a. Date (Mon	of Injury th, Day Year)	Injury	28c. Injury a Work? M 1 ☐ Ye	it os 2 N o				
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ng Phy fler this ineral d	Certification: To B	1 Yes 2 Ho 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no determin	28a. Date (Mon O8/) 28e. Place build	of Injury th, Day Year) 19/07 1 of Injury - At honing, etc. (Specify) Sing hour	Injury Unknown 19, farm, street	M 1 ☐ Ye	s 2 X No	Subject 28f. Location (S City or Tow	choked	l on bolus of for bor or Aural Route Number, B17 East Parkhi	
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To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	edical Certification: To B	27. Manner of Death Tension Tension	28a. Date (Morn O8/: 28e. Place build Nurs Physician: To the xaminer: On the band man	of Injury th, Day Year) 19/07 2 of Injury - At hon ing, etc. (Specify) Sing hom a best of my know asis of examination ner stated.	Injury Unknown ne, farm, streel ledge, death o on and/or inves	nd 1 Tye , factory, office courred at the time, tigation, in my opin 29c. License in D-178	date and place	Subject 28f. Location (5 City or Tow Dr. Bet), and due to the curred at the time, it	choked Street and Num yn, State) hesda cause(s) and m date and place.	l on bolus of for the or Rural Route Number, 117 Fast Parkhi 110 anner as stated. and due to the cause(s)	
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To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	edical Certification: To B	27. Manner of Death That was been described by the control of t	28a. Date (Mon O8/: 28e. Place build Nurse Physician: To the xaminer: On the band man 22 and man 24 and man 25	of Injury th, Day Year) 19/07 19 of Injury - At hon ing, etc. (Specify) 5 ing hom a best of my know asis of examinationer stated.	Injury Unknown ne, farm, streel ledge, death o on and/or inves 23a) (Type, Pri	Interpretation of the state of	date and place	Subject 28f. Location (5 City or Tow Dr. Bet), and due to the curred at the time, it	choked Street and Num yn, State) hesda cause(s) and m date and place.	ber or Rural Route Number, B17 East Parkhi D anner as stated. and due to the cause(s)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death **Physician** 1:20P.M. Walter Ray Huff, Jr. 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 577-44-2131 72 Director Jan. 21, 1935 Washington, D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at MD Anne Arundel Pasadena 1 ☐ Yes 2X No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9309 Fort Smallwood Road USA 21122 Funeral ıral", or items 2 I Examiner πυ 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1数Yes 2回No If Yes, Give Year or Dates: Korean 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Insurance Agent Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Ray Huff, Sr. Katie Fischer ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, MD 21122 Nancy M. Huff/Wife 9309 Fort Smallwood Road Important: If Item 27 any injury or other tr once. Aug. 27, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 Removal from MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 7411. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death imediate Caus (Final lisease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d Date of delivers 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes X No. 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 4 Nursing Home 5 Residence 6 ☐Other (Specify) . Date of Injury (Month, Day Year) Manner of Deat 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. Hospital or Attending

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

item 27 i

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"natural"

land 21215-0036

Mary

Baltimore,

Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

Medical

M of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** August 24, 2007 7:43 A.M Janet Elizabeth Isner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Olney Montgomery Montgomery General Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 M 2 F Yrs. Aug. 28, 1922 IA 325-14-6932 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" ~ " any injury or other traumatic event." 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Directo Falls Church, Fairfax VA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 22043 1829 Olney Rd. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emily Otto Leroy Rudolph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1829 Olney Rd., Falls Church, VA 22043 19a. Informant's Name/Relationship (Type. Print) 1829 Olney Rd., Falls Church, David R. Stevenson/Son-in-law Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug.29,2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Servio - Link nsee 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to for as a consequence of): Examiner Sequentially list conditions, it any least good immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Myeloptoliferative
Dubto (or as a consequence of): The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, physician Physician/Medical the for use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death as been signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be Hospital: 1/2 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) atano 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Tes this 27. Many of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Te 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Mogth, Day, Year) 29c. License number 29b. Signature and title of ce 30. Name and address of person who completed cause Dr. RAWHMAR 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Nev 1/2001

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglene Important: If item 27 is marked other tha any Injury or other traumatic event, the once.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at show

Items 23a or 2 ner must be n

r than "natural", or Items 23a the Medical Examiner must t

Director

Funeral

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Completed

Be

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with the Maryland

death v

72 hours after

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division or Vital

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death.

Hospital or At 24 hours after d

24 hours after death e Funeral Director: filled in by the

To the From To the From To the Fromple

certificate be executed burial-trar attending physician the nse

Examiner Physician/Medical signed by t þ Completed ge 2 s certificale has director, po Be 2 After t Certification:

23b. Was decedent pregnant in the past 12 months? 9 Unknown

4 ☐ Homicide

29a. Certifier

and manner stated.

Intractable Gastr-paresis, Dyspriagia

25. Was case referred to medical examiner?

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 🎉 No

Hospital: 1 Mapatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Xiatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D53362 29d. Date signed (Month, Day, Year)

8/20/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20902 M.D. 9801 Georgia Ave, #117, Silver Spring, MD

State Registrar

Medical

		_	negistiai .	rtificate of Death	Req	g. No. 2007 29074
	Physicia	an	Decedent's Name (First, Middle, Last)		Month	21, 2007 /252 ₀ M
	/Medic		Jayson Charles Jewell 4a. Facility Name (If not institution, give street and number)	4b. City. Town, or Location of Death	August	4c. County of Death
	Examin	er	12252 Stoney Bottom Road	Germantown		Montgomery
****	Funeral	2	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	
	Director		543-84-9105 1⊠M 2□F 40 Yrs.	Months Days Hours Min.	Feb. 14,	1967 Florida
	pt.		Usual Residence of Decedent 10a State 10h County 10c. City, Town or L	ocation		10d. Inside City Limits
	arylar show d at	_				1 ☐ Yes 2 XNo
	he Ma 8a-f	ecto	Maryland Montgomery Germant		10	lg. Citizen of What Country?
	with the	ā	10e. Street and Number	10f. Zip Code 20874	10	
	eath is 23	eral	12252 Stoney Bottom Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.		ecify Yes or No-	United States 14. Race - American Indian,
•	fter d r item iner	Funeral Director	1 □ Never Married 2127 Married 1 □ Yes 2121 No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
	ursa al', o Exam	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No Specify:		Specify: White
	Should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of work	ring 1	6b. Kind of Business/Industry
7	ithin ne.	ng l	Flementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	_1	High Cobool
7	ed w lygier ner th			iter Network Speci	e (First, Middle, M	High School
<u>2</u>	be fil	Be	17. Father's Name (First, Middle, Last) Garv Stewart Jewell	To. Would strain	•	
Š	d Mer narke	우		ing Address (Street and Number or Ru.		
5	d 2 sh d 2 sh th and 7 is r traur		1 1 1			antown, Maryland 20874
ני	1 an Heal tern 2		20a Method of Disposition 20b Place of Disp	osition (Name of	Date 2	20c. Location - City or Town, State
5	ages ant of tt: If if		1 Burial 2 XICremation 3 Bernoval from State	itan Crematory 8/2	3/2007	Alexandria, Virginia
Dalumor	nit. F artme ortan injur			22. Name and Address of Facility De		
Ď	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev once.		Muchan & Salley 10) East Deer Park D	r., Gaith	hersburg, MD. 20877
H			23a. Part1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	est, Approximate Interval Between
į	Physician		Immediate Cause (Final disease or condition	102		Onset and Death
,	/Medical		resulting in death) Due to (of as a onsequence of):			ma
	Examiner	L	Sequentially list conditions, b. Kangrag			
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Linet Underlying Cause (Disease or injury			
	xecut and if-tran	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
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000	ificate g phy-	edical				
POX		N.	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery
	the death cer y the attendin ched for use	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5	Other (specify)		Month Day Year
л Э	at the	Physician/M	9 Unknown	dedition access in an in Bodd	220 Did tob	pacco use contribute to the cause of death?
s,	w requires that the d been signed by the should be detached	5	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		es 2 No 3 Probably 4 Unknown
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VII	Physician: The law t this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner? 1 ★ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpati	Othori	th Check onl one	ence 6 □Other (Specify)
o	F SE P	<u>۱:</u>	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		ow injury occurred
0	nding th. : Afte	tion	1 □ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation \(\hat{\Omega} \cdot \text{Q} \text{ 2 200 } \)	Work? 1 □ Yes 2 2 No	Hans	ing-sefinflower
DIVISION	Atter r dea ector by the	ifica	3 Suicide 6 □ Could not be determined 28e. Pace of injury - At home, farm, s	street, factory, office	28f. Location (St.	reet and Number or Rural Route Number, n, State) / 2 2 5 2 5 7 7 7 7
5	tal or s afte al Dir ed in	Certification:	7A 2	suc	Bottom	RN Germantown MD
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After the completely filled in by the funera		29a. Certifier (Check only (Ch	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the caurred at the time, d	ause(s) and manner as stated. 2057 ate and place, and due to the cause(s)
	the H nin 24 the F	Medical	one) and manner stated.	29c. License number		
	vitt To con	2	29h Signature and title of certifier			9d. Date signed (Month, Day, Year) Augusta 22 2007
•	1		30. Name and address of person who completed cause of death (Item 23a) (Typ	Deint 2 (2)	100	60
			30. Name and address of person who completed cause of death (Item 23a) (Typ ILA ~ BRECKER, MD OME	Silver Spi	Cal Fo	10 20901
	Sta	ate	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	1		
	Regist	rar	AUG 2 7 2007 France 16 4	LABARY J		

State of Maryland / Department of Health and Mental Hygiene 2007 29075 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician WWa 08 OH N 07 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Medical Center Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, May 12, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 € Months Year 941 VA . 66 Director 226-56-2931 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow of Heelth and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-1 ehov other treumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2X No Upper Marlboro Prince Georges Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 USA 5605 South Marwood Blvd #214 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Oecedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after I ☐ Yes 2 🛣 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: 3 XWidowed 4 ☐ Divorced **Black** Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Patent & Trademark Examiner 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 and 2 should be Maria Tates Sam Wines 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Upper Marlboro, Md. 20772 16414 Mt. Calvert Rd. Gwendolyn Ledbetter/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges in Dapartment of Hamportent: If Ite eny injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-31-2007 Cheltenham, MD. 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 21. Signature of Funeral Service Licenses Marshall's Funeral Home, Inc. Washington, DC 20011 4217 9th ST. N.W. P.M. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Oue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit the ettending physician and hed for use as the burial-trar Due to (or as a consequence of). Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e Division of Vital Records, P.O. 9 Unknown 9 Unknow6 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should I 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy cartificate 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA this I Director: Aftar this d in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter 4 T Homicide Within 24 hours etter Within 24 hours etter To the Funerel Dir 1 Certifying Physician: To the best of my knowledge ideath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner rated. 29a. Certifier Medical and m anner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) *u* u ho completed cause of death (Item 23a) (Type, Prigt) Name and address of per HAH WAY ANNAPOLIS MAZIYOF EFENSE w 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 7007 9-30AM helma Johnson -ugnst /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** en NIJE Washington Medical Center Anne Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | NOV | 12. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Ye*ar)*921 1 ☐ M 2 ☑ F Maryland **Director** 215-16-5262 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 375 Jennings Rd. 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married , o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th 0 <u>Homemaker</u> <u>Caregiver</u> and Mental Hygir is marked other permit. Pages 1 and 2 should be flied Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vernon Smith Nancy Stepney ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 McKinsey Rd. Severna Park, Md. 21146 Saundra Parker (Daughter) 20a. Method of Disposition 20c. Location - City or Town, State 24 Sprofepopin Handreck 1 Burial 2 □ Cremation 3 □ Removal from State Church Cemetery 8-22-07 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Md. 21. Signature of Funeral Service Licensee WinName Redese of &aciliSons Mortuary, 821 West St. Annapolis, Md. 21401 davy Deese M00483 23a. Part I. Enter the disease, or confications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examine attending physician and for use as the burial-tran Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown the as been signed by the should be detached Records, P. Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. þ 2 V No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 250No 24a. Was an certificate has autopsy performed? Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA P this ō funeral 28a. Date of Injury (Month, Day Year) 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Division Certification: Hospital or Attending 5 ☐ Pending investigation Injury 1 atural To the most after death.

Within 24 hours after death.

To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

150

Q

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician AUGUST 25 2007 10:15PMM GLENN LESTER KEHR, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner STEVENSVILLE **OUEEN ANNES** 108 STATE STREET If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Director 84 AUGUST 12, 1923 PENNSYLVANIA 218-18-3196 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 28a-f show notified at 1 ☐ Yes 2 No Director MARYLAND QUEEN ANNE'S STEVENSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō ber within 72 hours after death with or items 23a 108 STATE STREET 21666 UNITED STATES **Examiner must** Funeral Race - American Indian, Black, White, etc. 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1943—1945 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Dispartment of Health and Mental Hygien
Important: If item 27 is marked other the
any injury or other traumatic even PLUMBER PLUMBING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGE C. KEHR ANNIE B. STAUFFER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY A.KEHR/WIFE 108 STATE STREET, STEVENSVILLE, MARYLAND 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition AUGUŠT 29 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) STEVENSVILLE CEMETERY 2007 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service License FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter to discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear printer. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to or as a conjunuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 Unknown 1 X Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No page 2 certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA P To the Hospital or Attending Physe within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 27 Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division or Vital Records,

d title of certifie

DAVID SMITH, _M.D.

29b. Signature 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8221 TEAL DRIVE, SUITE 302, EASTON, MARYLAND 21601

29c. License number

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar		State	of Mary			rtment of F tificate of			/lental H		200	7	2007	5
y			Negistral Decedent's Nan	ne (First, Middle,	Last)	1/			outo or			2. Date of D	eath			3. Time of Death	U
	Physicia Medic			Alger	V.	Ker	ner	-				Augus	+ 2	79	1	2:50P	M
	Examin		4a. Facility Name ((If not institution,	give street and nu	ımber)			4b. City, Town, o			,		County of D			
			Renaissance		@ Riderwood		J.	hdov)	Silver	-	ig der 24 Hrs.	0 Date of B		tgomer		/Ct- t F	
	Funeral Director		5. Social Security I	70	1 X M 2□F	7. Age (III 85	yrs. last birti	Yrs.	Months Days	Hour		8. Date of B (Month, L Jul 30,	Day, Year)	9.	Counti		gn
	and		Usual Residence of 10a. State	10b. County		100	c. City, Town	or Loca	ation						10	d. Inside City Limi	ts
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20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hydiene. Important: If item 27 is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral	11. Marital Status1 □ Never Mar3 □ Widowed	rried 2∑ Marrie 4 ☐ Divorced	If Yes G	orces? 2 ☐ No			as Decedent of H Yes, specify Cub ☐ Yes 2X No	Hispanic an, Mexi Spec		pecify Yes or No Rican, etc.)	10-	14. Race - A Black, V Specify:	Vhite, e		
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=	f be findal Hed of	Be	Henry P.	•	.ast)						elsinia		е, маюеп	Surname)			
Š	should be nd Mental marked c	မှု	19a. Informant's N		ip (Type, Print)		19b.	Mailing	Address (Street	L			her City o	r Town, Sta	te Zin I	Code)	
	and 2 sealth ar n 27 is ier trau		Gertrude J		/Wife			-	racefield							*	
ני ב	ss 1 a of Hez item		20a. Method of Dis			20			ition (Name of atory or other pla			Date	1	cation - City			
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.C. DO	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknown	2 months? □-No		birth 2 🗌 nant at time	Fetal death		Ectopic pregnanc Other (specify) _	у				23d. Date of Month		y Day Year	
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2	Attending Physician: r death. ector: After this certifice by the funeral director, I	ation	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investiga	(Mo ation	nth, Day Yea		njury	28c. Inju Wo M 1	rk? Yes 2	: 🗆 No	200. Describe	s now inju	y occurred			
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	and Zoe. Place	e of injury - ding, etc. (Sp	At home, far pecify)	m, stre	et, factory, office			28f. Location City or T	(Street ar own, State	d Number o	or Rural	Route Number,	
	te Hosp 124 hou e Funei	Medical	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical E	Physician: To the examiner: On the and ma	ne best of my basis of exa nner stated.	knowledge mination and	, death d/or inv	occurred at the ti estigation, in my	me, date opinion,	e and place death occu	, and due to th rred at the tim	e cause(s e, date an) and manne d place, and	er as sta I due to	ated. the cause(s)	
	Vithir Withir Comp	Me	29b. Signature and	d title of certifier	P. 10		. 14	N	29c. Licens				29d. Da	te signed (A	Aonth, E	Day, Year)	
/	5+1		30. Name and add	dress of person v	vho completed cau	use of death	(Item 23a) (Type, P	1-1 4)	952		0	0 0-	JUST	10	2007	
			LOVEEN	J. PU	TH UM A	NA ?	3110 E	RA	CEFIEL	DK	UAD,	SILVE	KSPI	CING,	UN	20-104	_
	Sta Registr		31. Date filed (Mo	AUG 24	2007	gistrar's S	Signature	6	ents)								
SUL	/H 17 Rev 1/20	201						-					_				

DHMH 17 Rev 1/2001

		For State Registrar	State of Maryland		artment <i>rtificate</i>			d Menta	al Hygien Reg. N	e 2007	7 2907
E 75		1. Decedent's Name (First, Middle, Last,						Mo	te of Death onth D	av Yea	Time of Deat
Physic /Med		Alfred Francis	King					Aug	gust 24	, 2007	1:00 p
Exam		4a. Facility Name (If not institution, give	street and number)		4b. City, To	own, or Loc	ation of De	eath	4	c. County of De	
		4811 Creek Shore				ckvill					ntgomery
Funera Directo		5. Social Security Number 6. Sec. 125	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months		Under 24 h	Ain. (Mo	te of Birth onth, Day, Yea rch 30,	r) 1920 W	Birthplace (State or Fore Country) Vashington,
pu ,		Usual Residence of Decedent 10a, State 10b. County	10c City	, Town or Lo	ncation						10d. Inside City Lim
Maryla a-f shov	tor		lontgomery		Rockvil	lle					1 □Yes 2 🔀
h the or 28a	ire	10e. Street and Number			10f. Zip C	Code			10g. 0	Citizen of What	Country?
th will 23a c Ist be	a	4811 Creek Shore	Drive				20852			USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	S. 13.	Was Decede If Yes, specif 1 ☐ Yes 2			? (Specify Yourdon) Puerto Rican,	es or No- etc.)	14. Race - Al Black, W Specify: Wh	
d within 72 hours aff giene." natural", or the Medical Exami,	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or 5+)	16a. Dece (Give life.	edent's Usual e kind of work DO NOT use	Occupation done during retired)	n ng most of	working	16b.	Kind of Busine	ss/Industry
with iene.	E	Elementary/Secondary (0-12)	4	Acco	ountant	t			Gov	ernment	Accountin
Hyg other ent,		17. Father's Name (First, Middle, Last)				18.	. Mother's	Name (First	, Middle, Maid	en Surname)	
ld be ental ked	To Be	Alfred J. King						Jenni	e Mahon	ey	
Mal ylallo nd 2 should be file lith and Mental Hy 27 is marked oth r traumatic eveni	-	19a. Informant's Name/Relationship (T	rpe. Print)	19b. Mail	ing Address (Street and	Number o	or Rural Rout	te Number, Cit	y or Town, Stat	e, Zip Code)
IVIC nd 2 alth a 27 is r trau		Mary N. King/Wife	.	4811	Creek	Shore	e Dri	ve, R	ockvill	e, MD 2	20852
S 1 a f He gittern other		20a. Method of Disposition	20b. F	Place of Disn	osition (Name	e of		igust :		Location - City	
age ento		1 ★Burial 2 ☐ Cremation 3 ☐ I	Removal from State	-	Heave		etery	200	7 Sil	ver Spi	ring, Maryl
permit. Pages 1 a Department of Hee Important: If item	2	21. Signature of Funeral Service Licens		i i						lome Inc	ing, MD 20
Physicia		23a. Part1. Enter the disease, or comp shock, or heal failure. List only of Immediate Cause (Final disease or condition	lications that caused the leat one cause on each line. Metastatic	h. Do not er	nter the mode	of dying, s	such as car	rdiac or resp	iratory arrest,	ver sp.	Approximate Interval Betweer Onset and Death
executed sale be executed this sician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Adenocarci Due to (or as a conseq c	noma «	of Pro	state					3 Years
the death certificate y the attending physicached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1□Live birth 2□Feta 4□Pregnant at time of c 9□Unknown	al death 3	⊑Ectopic pre □ Other <i>(sp</i> e					23d. Date of Month	delivery Day Year
w requires that the deben signed by the should be detached	<u>چ</u>	Part II. Other significant conditions of	ontributing to death but not res	ulting in the	underlying ca	ause given i	n Part I.	_ 2			e to the cause of death] Probably 4┺JUnkn
The lar	Completed							_	4a. Was an autopsy performed □ Yes 2 X	? prior	e autopsy findings avail to completion of cause h? Yes 2 ☐ No
vital r sician: Th s certificate lirector, pag	Be (25. Was case referred to medical examiner?					6. Place of	f Death (Che	eck only one)		
ys is	2	1 ☐ Yes 2x No	Hospital: 1 ☐ Inpatient 2 ☐							e 6 □Other (Specify)
		27. Manner of Death 12 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28	8c. Injury at Work? 1 ☐ Yes	t s 2∐No		Describe how in	njury occurred	
4 0 0 5	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, s fy)	street, factory	, office		28f. L	ocation (Stree City or Town, S	t and Number o tate)	r Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my known inner: On the basis of examination and marker stated.	owledge, de ation and/or	ath occurred a investigation,	at the time, , in my opin	date and nion, death	place, and d	ue to the caus the time, date	e(s) and manne and place, and	er as stated. I due to the cause(s)
	Me	29b. Signature and title of certifier				D2153					Month, Day, Year) 24, 2007
10		30. Name and address of person who Gabriel Peter Pu		m 23a) (Type L510 O	e, Print) 1d Geo	rgeto	wn Ro	oad, R	ockvil	le, MD	20852
	State	31. Date filed (Month, Day, Year)	32. pegistrar's Sign	ature	la to						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 29080 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death STEVE KOUTSOUKOS 23, 2007 7:02 PM August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Casey House Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, August August 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2□ F 220-60-0036 4,1926 Greece Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 413 Christopher Ave. 20879 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bartender Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Koutsoukos Angela Adamopoulos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Argiro Koutsoukos 413 Christopher Ave. Gaithersburg, MD 20879 ^{Date} 27, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD Parklawn Mem. Park 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Urinary Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

/Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

"natural", or items 23a or 28a-f sho edical Examiner must be notified at

the Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me

Director

Funeral

ģ

Completed

MD

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Physician

attending physician and for use as the burial-tran signed by the at d be detached for s certificate has b

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Examine Completed by Physician/Medical Be Certification: To

To the Hospital or Attending Physician: within 24 hours after death.

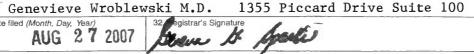
To the Funeral Director: After this certific completely filled in by the funeral director, Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectop	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part ii. Other significant conditions	contributing to death but not re-	sulting in the underlyin	g cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
Metastatic Colr	Cancer			1 ☐ Yes	2X No 3 Probably 4 Unknown
Prostate Cancer	:			24a. Was an autopsy performe	
25. Was case referred to medical examiner?			26. Place of De	eath Check onl one	
1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence	ee 6 MOther (Specify) Hospice
27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	
3 Suicide 6 Could not be determined			tory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occur ation and/or investiga	red at the time, date and plaction, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
29b. Signature and title of certifier	1. 0		29c. License number	29d	. Date signed (Month, Day, Year)
Kurnene	Brokele &	5 mid	D006461	- A	ugust 24, 2007

Rockville, Md. 20850

State Registrar 31. Date filed (Month, Day, Year) 27 2007 AUG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



		•	For State Registrar	State of	Maryland /	Depart Certin	ment of	Health a Death	and Me		ien 2 0 0	7 29081	
	Physici /Medic		1. Decedent's Name (First, Middle, HARD)	Last)	KIR	SCH	1			And US	1º25,2		u
	Examin Funeral			Greater Wa		pirthday) I	b. City, Town, Rock If Under 1 Yea Months Days	ville	24 Hrs.	B. Date of Birth Month, Day, 9/23/20	Montgo Year)		j n
12	Director • • • • • • • • • • • • • • • • • • •	tor	058-16-8498 Usual Residence of Decedent 10a. State 10b. County Md. Montgo	omerv	10c. City, To					9/23/20		10d. Inside City Limit 1X Yes 2 N	
	th with the 23s or 28e	ai Director	10e. Street and Number 3449 Chiswich				10f. Zip Code 209	906		10	og. Citizen of Wh	nat Country?	
980	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Iteme 23a or 28e-f ehow event, The Moulical Examinational be notified a	by Funerai	11. Marital Status 1 ☐ Never Married 2 万 Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Forc d 1 XYes 2 If Yes, Give Year or Dat	es? □No WWII		s Decedent of es, specify Cu Yes 2X No			rfy Yes or No- lican, etc.)		- American Indian, , White, etc. White	
Baltimore, Maryland 21215-0036	ad within 72 h rgiene. er than "natu t, the Mudical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4		(Give kin	nt's Usual Occi nd of work don NOT use retir	e during mos ed)		g	Beauty	Supplies	
/land	o ≈ ° ≥	To Be (17. Father's Name (First, Middle, L. Max Kirsch	ast)					er's Name nnie	(First, Middle, M Goldm	Maiden Sumame, an)	
, Man	ages 1 and 2 should b nt of Health and Ments t: If Item 27 is marked f or other traumatic e		19a. Informant's Name/Relationshi Evelyn B. Kirso			-					City or Town, S Spring,	Md. 20906	
imore	Pages 1 ament of He ment of He ant: If Item lury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Specific Properties)		comet	tanı cramat	on (Name of tory or other pl d Cemet	ery 8	B/26/0			city or Town, State	
Ball	permit. Pag Depertment Important: It any Injury o		21. Signature of Funeral Service Li	censee		Dar 11	lame and Add nzansky 70 Rock	GOLdi GOLdi Ville	erg l Pike	Memoria Rockvi	l Chapel 11e, Md.	ls • 20852	
	Physician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List o timediate Cause (Final disease or condition resulting in death)	omplications that cau nity one cause on eac a	sed the death. Do	35%	1 6	UI	VG			Approximate Interval Between Onset and Death	
8760,	cate be executed bhysician end the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	r as a consequence	,	-/BR	[<i>147</i>	10n			_
O. Box 6	The law requires thet the death certifica 11e hes been signed by the attending ph 2ge 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birt	ome of pregnancy h 2 Fetal dea nt at time of death n		ctopic pregnan Other (specify)	су			23d. Date Mont	of delivery th Day Year	
rds, P.	quires thet n signed b uld be deta	þ	Part fl. Other significant condition	DEMEN	th but not resulting	in the unde	erlying cause g	pven in Part I	l.	23e. Did tob	1/	bute to the cause of death? 3 Probably 4 Unknow	'n
al Reco		Completed									y prined? de	ere autopsy findings availab for to completion of cause of eath?	le i
Division of Vital Records,	ding Ph h. After th funeral	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ition		Outpatient Time of Injury	28c. Inj	ther: 4 No	ursing Hom		e) ence 6 Other w infury occurre		
Divis	iel or Atten s efter deat al Director: ed in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin	and 28e. Place o	f Injury - At home, g, etc. <i>(Specity)</i>	farm, street	t, factory, office	9	2	8f. Location (St. City or Town	reet and Numbei n, State)	r or Rural Route Number,	
	To the Hospitel or within 24 hours efter To the Funerel Dir completely filled in	edicai	29a. Certifier 1 Certifying (Check only one)	Physicien: To the be xeminer: On the bas and manne	is of examination a	lge, death o and/or inves	ccurred at the stigation, in my	time, date ar opinion, dea	nd place, a ath occurre	nd due to the ca d at the time, da	ause(s) and man ate and place, ar	ner as stated. nd due to the cause(s)	
b	To the complete	Σ	29b. Signature and title of certifier	ans	Lilve	uny	D 29c. Lice	354	36	1	9d. Date signed	(Month, Day, Year) 125, 200, 1020852	7
	•		30. Name and address of person w					SERO	AD, &	DOCKVI	LLE, M	102085	2
	Sta Registi		31. Date filed (Month, Day, Year) AUG 27	2007	gistrar's Signature	190	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 9871 9-21-07 vt.
State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WMHS — MEMORIAL CAMPUS 5. Social Security Number 7 2 3 ~ 1 4 ~ 7 6 7 6 1 M 2 F 7 8 Yrs. CUMBERLAND 5. Social Security Number 7 2 3 ~ 1 4 ~ 7 6 7 6 1 M 2 F 7 8 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location PA Bedford Hyndman 10c. City, Town or Location of Death Hyndman 10f. Zip Code 1 5 5 4 5 11. Marital Status 1 Divers Married 2 Married 1 Dives 2 Married 1 Dives 2 Married 1 Dives 2 Married 1 Dives 2 Married 1 Dives 2 Married 1 Dives 2 Married 1 Dives 2 Married 1 Dives 2 Married 1 Dives 2 Married 1 Dives 2 Married 1 Dives 2 Married 1 Dives 2 Married 1 Dives 2 Married 2 Married 1 Dives 2 Married 1 Dive	4c. County of Death ALLEGANY alte of Birth Month, Day, Year) — 1 3 — 1 9 2 9 9. Birthplace (State or Foreign Country) P A 10d. Inside City Limits 1 \(\overline{\text{Y}} \text{Yes } 2 \subseteq \text{No} \) 10g. Citizen of What Country? US A
Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. Country of Death ALLEGANY ate of Birth Month, Day, Year) 1 3 - 1 9 2 9 9. Birthplace (State or Foreign Country) PA 10d. Inside City Limits 1 \rightarrow{\text{Yes}} es 2 \rightarrow{\text{No}} 10g. Citizen of What Country? USA Yes or No- 1, etc.) 14. Race - American Indian, Black, White, etc.
WMHS - MEMORIAL CAMPUS Funeral Director Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24 Hrs. 8. D. Months Days Hours Min. 5. William 1 If Under 24 Hrs. 8. D. Months Days	ALLEGANY ate of Birth Month, Day, Year) — 1 3 — 1 9 2 9 10d. Inside City Limits 1 ★ Yes 2 □ No 10g. Citizen of What Country? USA Yes or No- ,, etc.) 14. Race - American Indian, Black, White, etc.
Funeral Director 5. Social Security Number 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24 Hrs. 8. D. Months Days Hours Min. 6. Sex 1 1 Months Days Hours Min. 6. Sex 1 1 Months Days Hours Min. 6. Sex 1 Mont	ate of Birth Month, Day, Year) 1 3 - 1 9 2 9 9. Birthplace (State or Foreign Country) PA 10d. Inside City Limits 1 √Yes 2 □ No 10g. Citizen of What Country? USA Yes or No- ,, etc.) 14. Race - American Indian, Black, White, etc.
	1 Mres 2 □ No 10g. Citizen of What Country? USA Yes or No- N, etc.) 14. Race - American Indian, Black, White, etc.
PA Bedford Hyndman 10e. Street and Number 147 Pine Street 15545 11. Marital Status 1 Never Married 2 Married 1 1 1 1 1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10g. Citizen of What Country? USA Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc.
10e. Street and Number 10f. Zip Code 1 47 Pine Street 1 Marital Status 1 Never Married 1 Never Married 3 Widowed 4 Divorced 3 Widowed 4 Divorced 1 Ves. Give 1 Ves. Specify:	Yes or No- N, etc.) 14. Race - American Indian, Black, White, etc.
The state of the s	Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc.
11. Marital Status 1. Married Status 1. Married Proces? 1. Marr	n, etc.) Black, White, etc.
The second of th	16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machinist	Railroad
De State Telephone (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	st, Middle, Maiden Surname)
Debug of the first	
Dorothy H. Kreigline 147 Pine St., PO Box 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date	267 Hyndman, PA 15545 20c. Location - City or Town, State
1 Burial 2 Acremation 3 Agreemoval from State 1 Donation 5 Other (Specify) 1 Donation 5 Other (Specify)	07 Johnstown, PA
Date 20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Date 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 4 Donation 5 Other (Specify) 22. Name and Address of Facility 4 Home 169 Clarence	ey H. Zeigler Funeral St., Hyndman, PA 1554.
23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resistance, for heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MUTIPLE INJURIES WITH MEDICAL COMPLICATION	piratory arrest, Approximate Interval Between
Sequentially list conditions, transleading to immediate b. Due to for as a consequence off.	
og og og og og og og og og og og og og o	
dedical E	(X) Many 27, 200
So to to the past 12 months? So to	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Spool of the spinon of the spi	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown
Chronic obstructive pullage of the state of	24a. Was an autopsy findings available prior to completion of cause of
	performed? death? 1□ Yes 2☑ No 1□ Yes 2□ No
25. Was case referred to medical examiner? 1 Siyes 2 No 25. Was case referred to medical examiner? 1 Siyes 2 No eck only one) 5 ☐ Residence 6 ☐ Other (Specify)	
O 5 Fe Control of Party Control of Control o	Describe how injury occurred
Solution investigation investi	· •
28d. Little of Injury 1 28d. Little of Injury 2 28d. Little of Injury 3 28d. Little of Injury	Location (Street and Number or Rural Route Number, City or Town, State)
28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury. At home, farm, street, factory, office building, etc. (Specify) 29e. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29c. License number	due to the cause(s) and manner as stated.
29b. Signature and title of certifier D 25406	29d. Date signed (Month, Day, Year) Au6 ust 28, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7 21507
31 Date filed (Month Day Year) 32 Begistrar's Signature	01306
Registrar AUG 3 0 2007 Some & Aprile	

Registrar DHMH 17 Rev 1/2001 State of Maryland / Department of Health and Mental Hygiene 2007 2

			1 - For State Registrar		,	Cert	ificate	of De	ath	ı	Reg. No		2908	-
	Dhyoisi	20	1. Decedent's Name (First, Middle, La	st)						2. Date of Dea	ath Da	ıy Year	3. Time of Death	_
	Physici /Medic		Maurice I	eroy Kitt	rell					August			1533 ^M	
	Examin	er	4a. Facility Name (If not institution, give	e street and number)			4b. City, Tov	wn, or Loc	ation of Death			. County of Death		
		查	Southern Maryla				Clin		Under 24 Hrs.			Prince G		
L	Funeral Director		5. Social Security Number 6. S 622–28–3078 Usual Residence of Decedent	fex 7. Age	(In yrs. last				ours Min.	8. Date of Birt (Month, Day Feb. 9,	y, Year,) Cou	place (State or Foreign intry) olk, Va.	7
	Aaryland F show ed at	or	10a. State 10b. County		10c. City, T								10d. Inside City Limits 1 ▼ Yes 2 □ No	
	the N 28a-	rect	Maryland Prince (eorges	Tem	ple H	10f, Zip Co	nde			10a. Ci	tizen of What Cou	intry?	_
	with 3a or t be	Ö	4029 23rd Parkwa	av Ant 22			207					nited St	·	
	ms 2:	Funeral Director	11. Marital Status	12. Was Decedent 8	ever in U.S.	13. W			nic Origin? (Sp	ecify Yes or No- Rican, etc.)		14. Race - Amer	ican Indian,	_
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	lo		Yes, specify □Yes 2 [x		lexican, Puerto pecify:	Rican, etc.)		Black, White Specify: B1		
2-0	72 hc natul lical	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	1	6a. Decede	ent's Usual C	ccupation	n a most of work	rina I	16b. k	Kind of Business/I	ndustry	
7	rithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			etired)	g most of work	9				
2	led w lygiel her tl nt, th		12			Mecl	nanic	10	Made and a Mana	- (Fi-A A # d d d -	14-14-	Private		_
anc	l be fi	Be	17. Father's Name (First, Middle, Last							e (First, Middle, O. Kitt		•		
Ž	hould d Me nark natio	2	Sherman Hollov 19a. Informant's Name/Relationship	<u> </u>		10h Mailine	Addrage /S					or Town, State, Z	in Codo)	_
<u>8</u>	nd 2 salth an 27 is i		Wilhelmina Wash											
e,	ss 1 a of Hea		20a. Method of Disposition		20b. Plac	e of Disposi	ition (Name of	of erplace)		Date	20c. L	ocation - City or 1	Town, State	_
Ē	Pages ment of H ant: If ite ury or of		1 Burial 2 Cremation 3 ☐ 4 Donation 5 Dother (Speci	Removal from State (y)		yland	Veter	ans		1, 2007		heltenha	m, Md.	
Baltimore,	permit. Page Department Important: If any Injury or once.		21. Signature of Funeral Service Lice	nsee M 01 08		22. A	Name and A	ddress of er S rIboi	Facility Pope ro Pike	/Porest	vil:	le, Md.	20747	
			23a. Part . Inter the sease, or conshock, or heart failure. List only	plications that caused	the death. I								Approximate Interval Between	_
	Physician		Immediate Cause (Final disease or condition			CARD	IAC 1	NFAR	CTION	ر			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as										
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequen	ce of):								_
	cuted id ansit	Examiner	that initiated events	c										
o,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	a consequen	ice of):								
09/89	icate t physic	Medical		d										_
XOR	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 🗌 Fetal de	eath 3□E	Ectopic pregi					23d. Date of deli	very Day Year	
o.	the de y the a iched f	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of deat	h 5[]	Other (speci	ty)						
<u>з</u> ,	res that signed b		Part II. Other significant conditions DIABETES	contributing to death be	ıt not resultir	ng in the und	derfying caus	e given in	Part I.	23e. Did to		use contribute to	the cause of death?	
Records,	v requ	eted											· -	_
	sician: The law certificate has b irector, page 2 s	Completed by	STROKE HYPERTENSION	,)							osy irmed?	death?	topsy findings available ompletion of cause of	,
VItal	an: tifical tor, p		25. Was case referred to medical					26.	. Place of Deat	1 Yes th (Check only o	2 12 N	o 1 ☐ Yes	2□No	-
	Physician: this certific ral director,	o Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER	/Outpatient	3□ DOA	Othor				6 ☐Other (Spec	eifv)	_
ion or	nding Ph ith. r: After th e funeral	ation: T	27. Manne of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inju (Month, Day		3b. Time of Injury	28c.	Injury at Work?	2 □ No	28d. Describe I				
DIVISION	e Hospital or Attending P 24 hours after death. e Funeral Director: After t etely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home :. (Specify)	, farm, stre	et, factory, o	ffice		28f. Location (8 City or Tov	Street a vn, Stat	nd Number or Ru te)	ral Route Number,	
	To the Hospit: within 24 hours To the Funera completely fille	edical (nysician: To the best of miner: On the basis of and manner sta	examination									
	To the within 24	Me	29b. Signature and title of certifier	*			29c. L	icense nui	mber	1		ate signed (Month		_
+			+ TODRIC				P	403	24		AUG	SUST 2	7, 2007	
1	(2)		30. Name and address of person who	completed cause of do	eath (Item 23	Ba) (Type, P	rint)	CLI	NTON,	MARYLA	tno	, 20735		_
9	Sta	te	31. Date-filed (Month, Day, Year)	32. Registra	r's Signature	е								_
	Registr	ar	AUG 2 9 2007	E DA	do	RI								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** AUG 2007 6:40 P M JAYDEN ANTOINE KOROLEVICH-WHIMS 31 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/31/2007 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 10 Min 40 1 X M 2 □ F N/A Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 No Prince Georges notified Director College Park MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or be 20740 USA 9338 Cherry Hill Road ral", or items 23a Examiner must b Apt 1 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: γ Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) than, College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A N/A# is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file iment of Health and Mental Hitant: If item 27 is marked oth Be Candice Andrea Korolevich Whims Antoine ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9338 Cherry Hill Rd Apt 1 College Park MD 20740 Ysabel Korolevich Grandmother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 9/4/2007 Smithsburg Cremation Smithsburg , Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licensee 106 East Church Street Frederick, MD 21701 Ma M01176 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EXTREME PREMATURITY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the l ISe 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant I □Live birth 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1∐ Yes 2 √2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No I hours after death.

•uneral Director: A

ely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) n 24 hou the Funeral Direc. ۱۳۰۰ filled in b 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examine? On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certi D65419 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 MC USA SIEROCKA MAJ AGNES 31. Date filed (Month, Day, 32. Registrar's Signature Year) State 1 200 0

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Clyde Lewis, Ir. 01:10 A M 18. 2007 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center - Hospice Care Baltimore Baltimore if Under 1 Year | If Under 24 Hrs. 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**⊠** M 2□ F 214-30-7442 74 Director 27. 1932 Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 X Yes 2 □ No Director Maryland Harkord Havre de Grace 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 107 Vandiver Ct. U.S.A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1953-1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: Completed by 3 Widowed 4 Divorced 1954 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Mail Carrier Government other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clude Clayton Lewis LouAnne Susan McMillion 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Jean Lewis (Spouse) 107 vandiver Ct. Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Rock Run Cemetery 08/22/2007 Havre de Grace. MD 4 Donation 5 Dother (Specify) 22. Name and Address of Zellman Mitchell Smith Funeral Home ture of Funeral Service Licensee Man 123 S. Washington St. Havre de Grace, MD 21078 28a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** disease or condition resulting in death) Lung Cancer Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes P.O. 9 Unknown 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page performed? Yes 2 🛣 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 AOther (Specify) Hospice 1 Yes 2 No 2 ER/Outpatient 3 DOA ို 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: d in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide after within 24 hours af

To the Funeral D

completely filled in To the Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) 6 bmc 6761 (0 3. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 1 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 24, Maude Elizabeth Lesher August 2007 9:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hagerstown Ravenwood Lutheran Village Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex Age (In vrs. last birthday) Funeral Months Days Hours 1 □ M 2 1X F 95 Oct. 2, 215-34-7673 1911 Clear Spring Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 1130 Luther Dr. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White <u>م</u> 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Alice Miles Hull John Franklin Hull ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 56 Cavetown, MD 21720 Shirley Y. Lewis-niece Important: If item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 8-29-2007 4 ☐ Donation 5 ☐ Other (Specify) Clear Spring, Maryland Paul's Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N Hagerstown, MD 21742 Kluna 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Attexosclerate do vasculoro de /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 Other: 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient this 27. Marner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I Director: After t d in by the funera Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of certifier D283 65 address of person who completed cause of death (Item 23a) (Type, Print) e flient WH-1 SHOPPI 36 32. Begistrar's Signature 31. Date filed (Month Year) State AUG 29 2007 Registrar

		•	For State Registrar	State of Mai	-	artment of H rtificate of L			Reg. No.	0 /	23001
	D lausiat		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici: /Medic		Dolores		La	ind		08	29 20	07	1:06 PM
1	Examin		4a. Facility Name (If not institution, give s				Location of Death		4c. County		on
			Williamsport N 5. Social Security Number 6. Sex		OME (In yrs. last birthday)	Willia	MSPORT If Under 24 Hrs.	8. Date of Birt	Wash		
	Funeral Director		573-38-8345 ^{1□}	м 2 ½ F	93 Yrs.	Months Days	Hours Min.	7/6/19	Year) 14	MI	place (State or Foreign ntry)
	and	1	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Maryl f eho	ō	WV Morgan		Berkele	y Sprin	.gs				1 ☐ Yes 2 No
	28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	N with	O E	2007 Valley Rd.			2541	1		USA		
	deet	Funeral		12. Was Decedent Ex Armed Forces?	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No Rican, etc.)	- 14. Ra Bla	ce - Ameri	can Indian, etc.
36	iges 1 and 2 should be filed within 72 hours after deeth with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28a-f show or other treumatic event, the Mudical Example I must be multified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates: U)		Specify:			'n∵Whi	te
ĕ	2 hou	pel	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind of E	Jusiness/Ir	ndustry
215	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	life.	kind of work done of DO NOT use retired	during most or work	ing			
2	filed wit Hygien other the	S	12	2		lurse				lical	
lug	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			ne)	
<u></u>	nould 1 Men narke	ဥ	Ernest Ross 19a. Informant's Name/Relationship (Ty	an Orient	10b Maili	ng Address (Street		Hunte		State 7	in Code)
ā	d 2 st th and 7 io n troun		David Land/Son	pe, Printj		30x 1245					
	1 and Healt Healt Hem 2		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Importent; if item 27 is any injury or other tre ange.		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Rosedal	matory or other place Le Cemet	erv 8/3	1/2007	Marti	.nsbı	ırq WV
Ħ	mit. Partme		21. Signature of Funeral Service Licens	90 .	22	2. Name and Addre	ss of Facility RO	sedale	Funer	al F	Home
m	Depa impo any i	9	Woh h. a	tell.	N	017 Ceme Martinsb	etery Rd ourg, WV	25404			
			23a art /. Enter the disease, or complish ck, or heart failure. List only of	cations that caused the cause on each line	the death. Do not enter	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician	9	linger date Cause (Final disease or condition	Acute	Cerebral	Throm	>04'5				Onset and Death 5 days
	/Medical Examiner		resulting in death)	Due to (or as a							,
	LAGITITIET	_	Sequentially list conditions,	Cerebro	consequence of):	Uisea	5e.			-	92.02
_	ted	in e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	000 to (01 as a	consequence or,						
	axecu n and al-trai	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
68760,	ificete be executed 3 physicien and as the burial-transit	edical	(d							
_	CD 01		IC CEMALE.								
Вох	eeth certifi attending I for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth 2	Fetal death 3	☐Ectopic pregnancy	,			ate of deliv	very Day Year
O.E	The law requires that the deeth cert ste has been signed by the attending page 2 should be detached for use s	by Physician/M	1 Yes 2 No	4□Pregnant at t 9□ Unknown	ime of death 5[Other (specify)					
P. 0.	that the	P.	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	underlying cause giv	ven in Part I.	23e. Did t	obacco use co	ntribute to	the cause of death?
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ital	an: T	0	25. Was case referred to medical				26. Place of Dea				
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Division of Vital Records,	Attending Physician: r death. ector: After this certification of the funeral director.		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time o	Wo	ryat rk? Yes 2 □ No	28d. Describe	how injury occu	ırred	
isi	death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, farm, st		103 2 2 10	28f. Location (Street and Nun	nber or Ru	ral Route Number,
S	al or A after i Dire	Certification:	4 Homicide determined	building, etc	. (Specify)			City or To	wn, State)		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Medical C	29a. Certifier 12 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner sta	f my knowledge, deal examination and/or in	th occurred at the time	me, date and place opinion, death occu	and due to the rred at the time,	cause(s) and r date and place	nanner as and due	stated. to the cause(s)
	To the within 2. To the complet	Mec	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ned (Monti	n, Day, Year)
	r ≤ F ö		> = TRHALL	am s		737	3700		Angust	- 29	. 7007
,	. 15		30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (Type	, Print)			,,,,,		,,
0	SH-6+1		TED E. HOWE, M	0 154	N. ART	IZAKU ST	, WILL	AMSFOR	T, ML	2 <	1795
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	Regist	rar	AUG 312	WII MAN	w D. D.	berei					

1 - For State Registrar

Bing

Physician

/Medical

Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item II per spouse G89I 5/27/09 dk
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 29088 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2007 10:32 A M August Juen Luan 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. | 19, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 XM 2 ☐ F Yrs. 1937 China 70 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No McLean 10f. Zip Code 10g, Citizen of What Country? USA 22102 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: Asian 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Self-Employed Real Estate 18. Mother's Name (First, Middle, Maiden Surname) Pei-Lau Hsu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 815 30th Ave., San Francisco, Ca. 94121 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Skylawn Memorial Park Aug. 28, 2007 San Mateo, Ca. 94402 22. Name and Address of Facility Money & King Funeral Home, Inc. 171 W. Maple Ave., Vienna, Va. 22180 Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 1□ Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

nture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed certificate has 25. Was case referred to medical Be examiner? မှ After this Manner of Death ai or Attending P Certification: 1 Natural 2 Accident neral Director: / 3 Suicide 4 Homicide fo the howard by the Funeral Directory filler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 20, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicole S. MD, Vetere, 9901 Medical Center Drive, Rockville, Md. 20850 AUG 2 4 State Registra DHMH 17 Rev 1/2001 **ORIGINAL**

			1 - For State Registrar		State of Ma	aryland / Depa <i>Cei</i>	artment of H rtificate of L	ealth and Death	Mental Hy	giene Reg. No		07	29089
	Dhamisi		1. Decedent's Name	(First, Middle, La.	st)				2. Date of De	aath Da	ıv	Year	3. Time of Death
	Physici /Medio		Linda Ka	ay Light	ner				Augh	-	26,	2007	05:50AL
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	death with the Maryland me 23a or 28a-f ehow Invest to notified at		Usual Residence of D 10a. State	10b. County		10c. City, Town or Lo	cation					10	d. Inside City Limits
	e Ma	Director	Maryland	Cec	i1	N	orth East						1 ☐ Yes 2 🛣 No
	or 28	Dire	10e. Street and Numi	ber			10f. Zip Code			10g. Ci	tizen of W	hat Count	ry?
	ath w			erts Way			2190				USA		
	er de item	Funeral	11. Marital Status	- 00 Maria	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🟋	Ever in U.S. 13.	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or Note (Note 1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	0-		- America c, White, e	
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ď	2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. Is marked other than "natural", or iteme 23s or 28s-f ehow raumatic event, its Medical Exercities marked and its motified.	Be	17. Father's Name (F	irst, Middle, Last)	1			18. Mother's Nar				e)	
Maryland 21215-0036	ould I Meni warke	٦ م		eatherma					a Gaily				
<u>a</u>	2 sh and and le m		19a. Informant's Nan				ng Address (Street a						Code)
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Balt	permit. Departimport import eny inj once.		21 Signature of Fund	eral Service Licer	Good On A	R.	Name and Addres T. Foard 1 S. Quee	Funeral	Home,	P.A.	, up MI	210 ח)11
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_	death certificate be executed e attending physician and of for use as the burial-transit		IF FEMALE:		23c. If yes, outcome	of pregnancy					004 0-4-	-6 -1-15	
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<u>E</u>		0	25. Was case referre	d to medical			.e.c.	26. Place of Dea	1000	2 X No	3 11	163 2	: 🗆 🔟
	d is	ToB	examiner? 1 ☐ Yes 2 Z N	o	Hospital: 1 Inpatie	nt 2 ER/Outpatien	t 3 DOA Othe	F. 4 Nursing H	lome 5 ARes	idence	6 Other	r (Specify))
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Division of	~ ~ • •	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubuilding, etc	ry - At home, farm, stre . (Specify)	eet, factory, office		28f. Location (City or To			r or Rural	Route Number,
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	Medicai (29a. Certifier 1 (Check only 2 one)	Certifying Ph	ysician: To the best on niner: On the basis of and manner sta	of my knowledge, death examination and/or invited.	occurred at the tim restigation, in my op	e, date and place inion, death occu	a, and due to the urred at the time,	cause(s date an	and man d place, ar	nner as sta nd due to t	ited. the cause(s)
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			For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of				jiene	2007	7 29	1090
	0		1. Decedent's Name (First, Middi	le, Last)					2. Date of Dea	th			of Death
	Physici /Medio		Ward William 1	Long					Month August	26.	2007	2::	25 A ^M
	Examin		4a. Facility Name (If not institution	n, give street and numb	per)	4b. City, Town,	or Location	of Death		4c. C	ounty of De		
			Calvert Manor				ng Sun				Ceci		
r	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday	If Under 1 Yea Months Day:		Min.	8. Date of Birth (Month, Day	(, Year)		irthplace (Stat Country)	
	Director		212-01-4783 Usual Residence of Decedent		88 Yrs.				May 18,	, 191	.9	Maryl.	and
	yland		10a. State 10b. County	,	10c. City, Town or L	ocation.						10d. Inside	City Limits
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	th the	Director	10e. Street and Number			10f. Zip Code			1	l0g. Citize	en of What 0	Country?	
	23e		1881 Telegraph	n Road		219	911				USA		
	er deg	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	Was Decedent of If Yes, specify Cu	Hispanic Or ban, Mexica	rigin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)	14	4. Race - An Black, Wh	nerican Indian	,
36	s afte	by Fu	1 Never Married 2 Mar 3 ☑ Widowed 4 Divorced	If the Cive	□No	1 □ Yes 2 X No	Specify:	:		5	Specify:		
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. sd other then "neturel", or tlems 23e or 28e-1 show event, the Medical Evaninar must be notified at	ed b		Year or Date		edent's Usual Occi	unation.			16h Kin		White	
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	e filec of he vent,	BeC	17. Father's Name (First, Middle,	Last)			18. Moth	er's Name	(First, Middle,				
/lai	Mente Mente arked	To E	Theodore F. Lo	ong			Ad	rian	Evans				
Maryland	s 1 and 2 should be f Health and Mental item 27 Is marked o other treumatic ev		19a. Informant's Name/Relations		19b. Mai	ing Address (Stree	et and Numb	er or Rura	l Route Number	r, City or	Town, State	, Zip Code)	
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altimore,	ges 1 au t of Hea If item or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation	3 □Removal from St.	ate 20b. Place of Disp cemetery, cre	osition (Name of ematory or other pl	ace)	D	ate	20c. Loca	ation - City o	or Town, State	
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Ba	permit. Pages. Department of I Importent: If ite eny Injury or of once.		21. Signature of Emeral Service	MI Vk	R	22. Name and Add • T. Foa 11 S. Qu	rd Fun	iera1	Home, I	P.A. 2 Sur	ı. MD	21911	
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that cau t only one cause on eac	ised the death. Do not er	nter the mode of dy	ving, such as	cardiac o	r respiratory arr	est,	-,	Approxin Interval	Between
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	/Medical Examiner		resulting in dealh)	Due to (or	as a consequence of):							1 1	
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	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):		•					15	
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687	fficate p physics the	edicai		0.	1 = (1 = 11 = 1	7110	SCVE	V 0					-v-3
Box	that the death certifitied by the attending to detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco		,				23	d. Date of d	elivery	
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnar	nt at time of death 5	□Ectopic pregnan □ Other <i>(specify)</i>	cy 				Month	Day	Year
P.O.	at the by th tache	hys	9 Unknown	9□ Unknow	'n								
	requires that the	by	Part II. Other significant conditi	ons contributing to dear	th but not resulting in the	underlying cau <i>s</i> e g	iven in Part I	l.	23e. Did to			to the cause of	of death?
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Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?						(Check only or				
of	di is	2	1 Yes 2 No 27. Manner of Death	Hospital:		AIL JU DOA			ne 5 Reside			pecify)	
no	ding h. Atter funer	tion	1 ■Natural 5 □ Pendir	28a. Date of (Month, igation	Injury 28b. Time Injury	W	uryat ork? ⊒Yes 2.⊟		28d. Describe h	ow injury	occurred		
Division	or Attending after death. Director: Attel in by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be 390 Place of	f Injury - At home, farm, s				28f. Location (S	treet and	Number or i	Rural Route N	lumber.
Ö	after Dire	Certification:	4 Homicide determ	building	, etc. (Specify)				City or Town				
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyin	ng Physician: To the b	est of my knowledge, dea	th occurred at the	time, date ar	nd place, a	and due to the c	ause(s) a	nd manner	as stated.	
	n 24 n 24 he Fu	edical	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examination and/or i	nvestigation, in my	opinion, dea	ath occurre	ed at the time, d	late and p	lace, and di	ue to the caus	e(s)
	To t To t	Σ	29b. Signature and title of certifie	er 1			nse number		2	29d. Date	signed (Mo	nth, Day, Year	r)
			> > Whole	m for		200	3443T	3		8	27	2007	
	10+1VA		30. Name and address of person										
1			Joseph K. Weig			lonial Wa	ay, Ri	sing	Sun, MI	219	11		
•	Sta Registr		AUG 2 8	2007	gistrar's Signature	ravie							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 23, 1. Decedent's Name (First, Middle, Last) **Physician** 2007 LUTSKY ∧ug. 1:40 A M Theodore /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery MOntgomery General Hospital 01 nev 8. Date of Birth (Month, Day, Year) 1951 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Florida 224-76-7128 55 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Silver Spring MOntgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20905 USA 14817 Peachwood Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ⚠ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Courier Delivery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Cohen David Lutsky ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14817 Peachwood Dr., Silver Spring, MD 20905 Michael Lutsky / brother Method of Disposition

1 □ Burial 2 △ □ Cremation 3 □ Removal from State

A □ Departion 5 □ Other (Specify)

A □ Departion 5 □ Other (Specify) 20c. Location - City or Town, State 20a. Method of Disposition August 24, 2007 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fundal Septe Licenses St., NW, Washington, DC 20012 254 CArroll 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BRAIN STEM CEREBRAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fat we a nonequence of Examiner burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending phase as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the aid be detached for ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ⊌nknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed after death

Director: 124 hours aft le Funeral Di letely filled in within 24 hou

To the Fune

completely fi

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exempler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

PHILIP DRIVE

29d. Date signed (Month, Day, Year) 200 F

and ddress of person who completed cause of death (Item 23a) (Type, Print)

D. KIEKLALDY 18101 PRINCE KOBERT

31. Date filed (Month, Day, Year) 2.7

29b Signature and title of continer

2007

istřar's Signature

Medical

State

Registrar

			1- State of Maryland / Dep Registrar Ce	artment of Health and M rtificate of Death	Tental Hygie Reg	^{ene} 2007 29092				
r	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death 11:30 A, M				
	/Medic	al	Evelyn Delphenia Lee 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	08-24-20	4c. County of Death				
7	Examin	er	Psalms 23rd. Senior Citizen Care	Fairmont Heights		Prince George's				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 日本 1 日本 2年 1 日本 1 日本 2年 1 日本	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You 02-26-19	9. Birthplace (State or Foreign Country) Spartanburg, SC				
	land ow It		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits				
	Mary Intervention	tor	Maryland Prince George's Fairmon	t Heights		1 MYes 2 No				
	or 284	Jirec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?				
	ath w s 23a nust b	ıral	700 61st. Avenue	20743		U.S.A.				
336	be filed within 72 hours after death with the Maryland ital Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Particol 11. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ♣No Specify:	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black				
21215-0036	72 hou nature lical E	ted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	edent's Usual Occupation	ing 16	16b. Kind of Business/Industry				
121	/ithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)		D.C. Public School				
d 2	led lygi lher nt, t		12th +04 Sch	18. Mother's Name	e (First, Middle, Ma					
Maryland		To Be	William C. Datcher	Mildred	d Harris					
lary	au s		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Rur						
	f and Health					MD 20782 c. Location - City or Town, State				
nor	ages ent of h t: If ite y or of		I Lapourial 2 Licremation 3 Linemoval from State 1	osition (Name of matory or other place) 1 Cemetery 08-30		uit_and, MD				
Baltimore,	permit. Pages 1 ar Department of Hes Important: If item any Injury or othe once.		21. Signature of Funeral Service Licensee m6/457	2. Name and Address of Facility		· · · · · · · · · · · · · · · · · · ·				
B	e a m e e					Suitland, MD 20746				
	Obvolejen		23a. Par1. Epfer the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ner the mode of dying, such as cardiac	or respiratory arrest	t, Approximate Interval Between Onset and Death				
	Physician /Medical		disease or condition resulting in death) a. Decubitus Ulcer Due to (or as a consequence of):							
**	Examiner		Sequentially list conditions. b							
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c							
Ć,	execur n and ial-trar	Examiner	that initiated events ' c c Due to (or as a consequence of):							
68760,	tificate be executed g physician and as the burial-transit	edical								
	± 0 6		IF FEMALE: 230 If you cuttoms of programs							
O. Box	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year				
, P.O	res that the de signed by the a be detached t		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?				
ords	w require been sig should b	q pa	Stroke		1 ☐ Yes	2 No 3 Probably 4 Unknown				
or Vital Records,	e law r has be	Completed by	Diabetes		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
alF	Iclan: The certificate hat ector, page		Hypertension			d? death? ☐No 1☐Yes 2☐No				
Σ	Physician: this certificatal director, I	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		h <i>(Check only one)</i> ome 5□ Residen	ce 6 Sother (Specify) Ass'tLivin				
10 U			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how					
Sio	Attending r death. ector: After	catic	2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No						
Division	i or Attend after death Director: /	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, s	treet, factory, office	City or Town,	et and Number or Rural Route Number, State)				
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea content of the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau	se(s) and manner as stated. e and place, and due to the cause(s)				
	To the within To the Comple	Me	29b. Signature and title of certifier	29c. License number		I. Date signed (Month, Day, Year)				
			Vaust perc	D0053235		8/29/07				
0.1	(5)		30. Name and address of persowno completed cause of death (Item 23a) (Type		Mary 1 and	20707				
1	Sta	te.		e Avenue Laurel,	maryland	20101				
	Registi		31. Date filed (Month, Day, Year) AUG 2 9 2007 32. Registrar's Signature							

D!		Tor State Registrar 1. Decedent's Name (First, Middle, Last)	- Tylair	Сег	tificate of	Death	2. Date of De			29093 3. Time of Death
Physic /Medi		Ethel Janette Lee	2						.6, 7		9:20A M
Exami	ner	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of Dea	ath	40	c. County of Death	
in a		Pineview Nursing	Home			Clinton	T. 1015-10411			Prince Ge	
Funeral Director		5. Social Security Number 6. Se 57.8-50-2186 Usual Residence of Decedent	TM 2XTE	ge (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Da	ay, Year	9. Birth Cou 1923 Virg	place (State or Foreign ntry) inia
inyland ihow		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
ne Ma 8a-f s	Sch	Maryland Prince Ge	orges	Clir	nton	7					1 X Yes 2 No
with the	Ö	10e. Street and Number				10f. Zip Code			10g. Ci	itizen of What Cou	intry?
eath	eral	9106 Pineview Lane	12. Was Decedent	Ever in III	C 12 1	20735		Chaoifu Voo or No		ISA 14. Race - Ameri	can Indian
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	•	1	Vas Decedent of H f Yes, specify Cub I ☐ Yes 2☐No	an, Mexican, Pue	erto Rican, etc.)	-	Black, White	
2 hou	ted	15. Decedent's Edu (Specify only highest grad	ication		16a. Deced	lent's Usual Occup	pation		16b. h	Kind of Business/Ir	ndustry
l within 7 jiene. r than "n the Medi	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done DO NOT use retire Wife	during most of w d)	orking	P	rivate	
e filec al Hyg othe vent,	Se C	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Middle	, Maidei	n Surname)	
should be tand Mental Is marked of umatic eve	To Be	Howard Jackson					Elsie 1	Bowles			
2 sho and I is ma	Ι.	19a. Informant's Name/Relationship (T)	•		19b. Mailin	g Address (Street	and Number or I	Rural Route Numb	er, City	or Town, State, Zi	p Code)
1 and 2 Health em 27 l		JoAnne Long - daug	hter	1	12304		ater Dr	ive Bowie	e, M	aryland	20721
tof F if ite or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State			sition (Name of natory or other pla	1	Date		ocation - City or T	,
it. Pa irtmer rtant njury		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens		PITE		Valley	Aug	25,07	Ann	adale, V	irginia
permit. Pages 'Department of H Important: If ite any injury or ot		21. Signature of Figure 21 Service Licens		D278				-		ral home	, D. C.2001
Physician		23a. Part1. Enter in disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition			n. Do not ente		ng, such as cardi	ac or respiratory a			Approximate Interval Between Onset and Death Years
/Medical Examiner	ı	resulting in death)	Due to (or as			ararovas	cular bi	осавс			years
Examiner	Ļ	Sequentially list conditions, if any, leading to immediate	b								
ted resit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ience or):						
certificate be executed iding physician and ise as the burial-transit	al Examiner	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):						
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death, To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 \overline{\overline{N}} No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	Ideath 3□	Ectopic pregnanc	1			23d. Date of delive Month	rery Day Year
ires that t signed by I be detac	þ	Part II. Other significant conditions co	ntributing to death b	ut not resu	ulting in the ur	nderlying cause giv	en in Part I.				the cause of death?
v requ	etec	Diabetes					·				
The law	Completed							24a. Was auto perfo		death?	opsy findings available ompletion of cause of 2 No
sicla: certi	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Oth		eath Check onl			
Phy er this eral di	.: To	27. Manner of Death	1 ☐ Inpatie	iry	ER/Outpatien 28b. Time of	28c. Injui	4 🛆 Nursing	Home 5 ☐ Resi 28d. Describe		6 □Other (Speci	fy)
nding ath. r: Afte e fund	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury		k? Yes 2 ∐ No		,	,	
al or Atte s after des il Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inj building, et	ury - At ho cc. (Specify	me, farm, stre	eet, factory, office		28f. Location (City or To	Street a wn, Stat	nd Number or Rur e)	al Route Number,
he Hospit n 24 hour ne Funera	Medical (29a. Certifier (Check only one) 1 □XCertifying Phy 2 □ Medical Exami	sician: To the best iner: On the basis o and manner sta	of examinat	wledge, death tion and/or inv	occurred at the tile restigation, in my	me, date and place opinion, death oc	ce, and due to the curred at the time	cause(s date ar	s) and manner as and place, and due	stated. to the cause(s)
withii To th	Me	29b. Signature and title of certifier				29c. Licens				ate signed (Month,	
4					>	D-	-18545		Aug	gust 23,	2007
		30. Name and domess of person who co									
		Dr. Philip Wisotsk				nter Sui	te 207	Waldorf	Mar	yland 20	602
Sta	ite	31. Date filed (Month, Day, Year)	32 degistr	ar s Signat	La A						

07-06601 Michael Scott Lease

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 29094

		For State	,		Certific	ate of i	Death				F	Reg. No.		
Physician ledical Examine	/ 1	. Decedent's Name (First, Midd	dle,Last) Michae	el Sc	ott 1	Lease					Month Day Year 1806 hrs			3. Time of Death 1806 hrs
Maria .	4	a. Facility Name (if not instituti Eugene Mason Recre	-	ber)		4t	Cumberla		cation of	Death 		4c. County of Death Allegany		
Funeral Director	5	5. Social Security Number 216–21–7789	6. Sex 7	. Age (in y	rs. last bir	thday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24Hrs. Min.	8. Date of E	,	M/DD/YYYY) 9. Birthplace (State or Foreign Country) MD	
₩ 출동 호립 (ompleted by Fulleral Director	WV Mineral Rid 10e. Street and Number 6 Diagonal Alley 11. Marital Status 1 XX Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Glive Year or, Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 17. Father's Name (First, Middle, Last)			in U.S.	10f. Zip Code 26753 10g. Citizen of What Count USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telemarketer 18. Mother's Name (First, Middle, Maiden Surname)						merican Indian, Black, c. Vhite ess/Industry		
, MD 21215-003 and 2 should be filed withi lealth and Mental Hygiene. treau 27 is marked other it traumatic event, the Med							Cindy Lou Miller g Address (Street and Number or Rural Route Number, City or Town, State, Zip Co PO BOX 118, Ridgeley, WV 26753					17		
Baltimore, M permit Pages I and 2 Department of Health Important: If item 2 injury or other traun		20a. Method of Disposition 1 XX Burial 2 Cremati 4 Donation 5 Other 21. Signature Funeral Service	Specify:		crema	ezer	tion (Name of er place) Ceme to ame and Add E. Ma	ery dress o	of Facility	08/28 Shaf:	o _{ate} 3/07 fer Fu	Rom	mney,	
	miner	23a. Pert I. Enter the disease, failure. List only one caus Immediate Cause (Final diseas or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause vents resulting in death) Las	se on each line. se a. Dr. whine Due to (or as a b. Due to (or as a	consequer	nce of):	not enter th	e mode of dy	ing, s	uch as ca	rdia'c or	respiratory a	arrest, sho	ck, or heart	Approximate Interval Between Onset and Death
Box 68760, e death certificate be executed the attending physician and effor use as the burial - transit	iysician/Medical E	XUNPENDED AMENDED A												
zal Records, P.O.	completed by	Part II. Other significant cond	cal				26.1	Place	of Death (Check o	1 24a. W au pe 1 Ye nly one)	Yes 2 as an atopsy arformed?	No 3	Probably 4 unknown re autopsy findings available or to completion of cause of ath? Yes 2 No
Division of Vispinal or Attending Physishours after death.	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pe 2 X Accident In 3 Suicide 6 Ce 4 Homicide 29a. Certifying	28a. Date (Month,	Day, Year) /25/20 e of Injury Found Comp	28t 07 Fn - At home, in Polex	otomac 	njury 28c pm 1 et, factory, of River n	. Injury	y at Work es 2 y uilding, etc River	(No c. csida	unk 28f. Location or Tow versi due to the o	n (Street an, State) de Comause(s) ansets	and Number	or Rural Route Number, City Cumberland, MD s stated.
To the within To the Comp	Medical	29b. Signature and title of cert	and manner st	tated			29c. L		number			29d.		(Month, Day, Year)
		30. Name and address of pers Donna M. Vincenti,	MD Assistant N	Medical I	Examine		l Penn St	reet,	Baltimo	ore, MI	D 21201			
Sta Registr	-	31. Date filed (Month, Day, Yes	1 0 2007 32. Re	ofstrar's S	ignature	S. S.	eds)				<u> </u>			
DHMH 17 Rev 1/20	01		DOVE		C	RIGINA	L							

			For State Registrar	State	e of Ma	ryland .	Depa / Cer	irtment of <i>tificate o</i>	Health ar f Death	nd Me	ntal Hyو ا	giene Reg. No	2007	29095
			1. Decedent's Name (First, Midd	e, Last)						2.	Date of Dea	ath Da	y Year	3. Time of Death
	Physici /Medio		Loretta M.	Littleto	on						8	25	2007	11:15 A ^M
	Examin		4a. Facility Name (If not institution	n, give street an	d number)			4b. City, Town	, or Location of	Death		4c	. County of Death	
			Atlantic Gene	ral Hosp	oital			Berlin				Wo	rcester	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖸	_	(In yrs. last		If Under 1 Year Months Day		Min.	Date of Birt (Month, Da	v. Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		219-14-4801	1 M 2 L		82	Yrs.			4	+/4/19	25		MD
	and *		Usual Residence of Decedent 10a, State 10b, County			10c. City, T	own or Lo	cation						10d. Inside City Limits
	Aaryli eho	ō	MD Worc	ester		Po	rlin							1 ☐ Yes 2 📉 No
	the h	Director	10e. Street and Number	ESLEI		ре.	L T T II	10f. Zip Code	9			10a. Cil	tizen of What Cou	ntry?
	with be or		302 Broad S	+					1811				USA	,
	ne 2;	Funerai	11. Marital Status		Decedent E	Ever in U.S.	13. V		of Hispanic Drigi uban, Mexican,	in? (Specif	y Yes or No	. 1	14. Race - Ameri	can Indian,
(0	riter	Fun	1 Never Married 2 Ma	ned 1 🔲	Yes 2.2AN	lo				Puerto Ric	ćan, etc.)	į	Black, White	
93	ours a	by	3	If Ye Year	s, Give or Dates:			☐Yes 210 N	lo Specify:				Specify: Wh:	Lte
5-0	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow he Modical Exeminer must be notified at	Completed	15. Deceder (Specify only higher	t's Education	ated)	1	6a. Deced	ent's Usual Occ	cupation	of working		16b. K	ind of Business/Ir	ndustry
21	Light of the light	npie	Elementary/Secondary (0-12)	Ť	ge (1-4or 5	+)			ne during most o ired)					
21	ygien ygien t, th	S	88				Hom	emaker					vn Home	
pu	d off	Be	17. Father's Name (First, Middle)								irst, Middle,		Sumame)	
<u> </u>	Men Men Marke	To	Charley Coo								Morr			
a a	2 sh and ie m		19a. Informant's Name/Relation		")								or Town, State, Zi	o Code)
ø	l end lealth im 27		Wanda Dero / d	aughter				road St	., Berl	in, M			ocation - City or T	State
0	ges if of h		1 Burial 2 Cremation		from State	cem	etery, cren	natory`or other p	olace)					
Baltimore, Maryland 21215-0036	t. Partituer	1	4 Donation 5 Other (Cape		open Cr	1	3/27/2			ankford, ral Home	DE
Ba	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if itam 27 ie marked other then "natural", or iteme 23a or 28a-1 ehow eny injury or other traumatic event, the Madical Examinar must be notified at once.		21. Signature of Funeral Service	Licensee					iam St.		_			
			23a. Part 1. Enter the disease	complications	that caused	the death. I							1011	Approximate
			shock, or heart lailure. Lis Immediate Cause (Final	only one cause	on each lin	e. /		95611	í -	Me	rid.	4		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	6/6	DIO	-v	470010	10	acc	lugo	7		
	Examiner			Du	ie to (or as a	a consequen	ce of):							
is		ē	Sequentially list conditions, if any, leading to immediate	b	ie to (or as a	a consequen	ce ol):	<u> </u>						
=	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<										
` .	execul in and ial-trar	Exa	resulting in death) Last	C	e to (or as a	a consequen	ce of):							
1/25	icate be executed physicien and s the burial-transit	edical		L _d										
1/2/2/2		edi												
2 % X	death certif e attending id for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant			of pregnancy 2 Fetel de		Estania sassa					23d. Date of deliv	rery
c∞ m	deall e atte	icla	in the past 12 months? 1 ☐ Yes 2 👿 No	4 🗆 8	Pregnant at	time of deat		Ectopic pregnal Other (specify)					Month	Day Year
P.O.	tt the by th tache	hys	9 Unknown		Jnknown									
- 0	w requires that the death cer been signed by the attendin should be detached for use	by P	Part Other signif and condit	ons contributing	to death bu	ut not resultir	ng in the ur	nderlying cause	given in Part I.		23e. Did to	obacco	use contribute to	the cause of death?
S. pro	equire en sig	ed	1119147							_	1 🗆 🗅	Yes 2	□No 3 Pro	bably 4 □Unknown
Li ナイトセルン ら/ tal Records	lawre as be	Completed									24a. Was		24b. Were aut	opsy findings available
	The lav	E									autor perfo 1 TYes	rmed? 2 🔊 No	death?	ompletion of cause of
Fe j	ilcien: Th certificete rector, pag	0	25. Was case referred to medica	1					26. Place o	of Death (C	Check only o	-	1 103	93110
543	Physicien: this certifice ral director, i	To B	examiner? 1 ☐ Yes 2 No	Hospital:	1 Inpatie	nt 2 ER	/Outpatien	3 DOA	Other				6 ☐Other (Speci	fy)
4	ding Ph J. After th funeral	i.	27. Manner of Death 1 Natural 5 □ Pendi		Date of Injur (Month, Day	y 28	b. Time ol	28c. In	jury at Vork?		d. Describe l			
HA I	Attending r death.	atic	2 Accident invest	gation			,=.,		☐Yes 2☐Ne	lo				
ofe,	or Att	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. I	Place of Inju	ry - At home (Specify)	, larm, str	et, factory, offic	C 0	281	. Location (S City or Tox	Street al	nd Number or Rur e)	al Route Number.
Lon Pil	ital o			1										
	To the Hospital or Attending Physicien: The within 24 hours eiter death. To the Funerel Director: Atter this certificate ha completely filled in by the funeral director, page	edicai	(Check only 2 Medica	Examiner: On	the basis of	examination	dge, death and/or inv	occurred at the estigation, in m	time, date and y opinion, death	l place, and h occurred	d due to the at the time,	cause(s date an) and manner as a d place, and due t	stated. to the cause(s)
	thin 2 thin 2 the mple	Med	one) 29b. Signature and title ol certific		manner sta	ted.		29c. Lice	ense number			29d Da	ite sign d (Month	Day Year)
	To To To		Signature and the or certain	111.	A A	^		6	11-115	85			01751	17
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	6A 5		30. If me and address of p in or	completed	cause of de	777	Ja.	1/4 1.10	1 //www	PK	Prliv	1	10 718	7/1
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T.	Registr		AUG 2	2007	Bear	e b	A	who						

			1 - For State Registrar		f Maryla	nd / Depa <i>Cei</i>	artment of F	lealth and N Death	_		2007		
ľ	Physici		Decedent's Name (First, Middle, MADLY)		MAR	Y	MEISTE	er.	2. Date of De Month Aug.	Day	Year 200	3. Time of Death 7 10:11P M	
	/Medic Examin		4a. Facility Name (If not institution,					r Location of Death		4c.	County of Dear		
			Madonna He					rettsvi				rford	
	Funeral Director		5. Social Security Number 407–22–3396	. Sex 1 □ M 2 1 0 F	7. Age (In yrs	i. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, D	ay, Year)	9. Bin -924	thplace (State or Foreign ountry) Ohio	
	D		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	ncation					10d. Inside City Limits	
	Maryli f sho	ō	,	rford	100.0	,,		rrettsv	rille			1 ☐ Yes 2 🛣 No	
	28a-	Director	10e. Street and Number	,1,0,1,0,1			10f. Zip Code	<u> </u>		10g. Citi	zen of What Co	ountry?	
	atter deeth with the Marylan or items 23e or 28e-f show infriet.rust be notified at	a D	1628 Dulaney	Drive				21084		Un	ited :	States	
	r des	Funeral	11. Marital Status	12. Was Dece Armed Fo 1 Yes	edent Ever in torces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	D^	14. Race - American Indian, Black, White, etc.		
9	hours after deeth with the Maryland turel', or Items 23e or 28e-f show al Examiner must be notified at	by Fi	1 Never Married 2 Married 3 MWidowed 4 Divorced	1 ☐ Yes If Yes, Giv Year or D	ve		1 □ Yes 2 🛣 No	Specify:			Specify:	White	
5-0036	in 72 hours "naturel", stulical Exp	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation		16b. Ki	nd of Business		
72	within 7. ene. then "n	Completed	(Specify onfy highest Elementary/Secondary (0-12)	grade completed) College (1	1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)					101		
7		Cou	12		4	Disa	bility	Examine 18. Mother's Nam				Security	
and	a da da	Be c	17. Father's Name (First, Middle, La	Arnel	1	Min 1	len		rell		Larue	Caudill	
Mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic	ဥ	19a. Informant's Name/Relationship		т_							Zip Code) 21084	
	and 2 ealth a n 27 is		Earl L. Mulle	n (Bro	ther)		W. Jar					ttsville,M	
altimore,			20a. Method of Disposition 1	□ Removal from	- 1	Place of Dispo cemetery, crei	osition (Name of matory or other place	ce)	Date	20c. Lo	cation - City or	Town, State	
Ĕ	. Pages Iment of tant: if it jury or o		4 ☐ Donation 5 ☐ Other (Spe	city)	Highv		m. Gard					Maryland	
n n	permit. Page Depertment of important: if eny injury or once.		21. Signature of Funerial Service Li	ensee	Viii.	_ 22	2. Name and Addre	ss of Facility	arret	tsvi	lle, I	Maryland	
			23a. Part1. Enter the disease, or co	omplications that of	aused the dea	ath. Do not ent					at Hoi	ne, P.A.	
	Physician		shock, or heart failure. List or Immediate Cause (Final	nly one cause on e	ach line.		-	-				Interval Between Onset and Death	
/	/Medical		disease or condition resulting in death)	Due to	(or as a conse	quence of):	KEAR	TPAIC	UKZ			2 YEARS	
	Examiner		Sequentially list conditions.	b. Co.	RONAR	Y AR	LTERY	PISEAS	ε.			10 EARS.	
2	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury										
2.	executed in and ial-transit	Exar	that initiated events resulting in death) Last	CDue to	(or as a conse	quence ol):							
58750,	licate be executed physicien and s the burial-transit	edical		d									
_	ertifica ling pt e as th												
X P	death certi e attending od for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live b	tcome of pregr pirth 2∏Fet nant at time ol	tal death 3	Ectopic pregnancy Other (specify)	1		2	23d. Date of del Month	ivery Day Year	
л. Э.	the d	hysic	1 ∐Yes 25€ No 9 □ Unknown	9□Unkno		30							
	w requires that the death certif been signed by the attending should be deteched for use a	by P	Part II. Other significant condition				nderlying cause giv	en in Part I.			A -	the cause of death?	
o	requir een si nould l		DIABETES	MELL	1705				10	Yes 2	No 3□Pr	obably 4 Unknown	
Vital Hecords,	2 2 2	Completed							24a. Was		24b. Were at prior to death?	topsy findings available completion of cause of	
ā	ysicien: The law is certificete has b director, page 2 s	င္ပ	25. Was case referred to medical						1□ Yes	No.		2 □ No	
=	ysicie s cert directo	OB	examiner?	Hospital: 1 🗆 I	Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	26. Place of Dea			Other (Spe	cifv)	
0	ng Ph Iter th	T:UC	27. Manner of Death SNatural 5 ☐ Pending	28a. Date		28b. Time o		y at	28d. Describe				
<u>S</u>	tendii leath. tor: A the fu	catle	2 Accident investiga 3 Suicide 6 Could no	t bo]	M 1 🗆	Yes 2 ☐ No					
DIVISION	To the Hospital or Attending Physicien: which 24 hours lefter death as the feath To the Funeral Director. After this certifical completely filled in by the funeral director.	Certification:	4 Homicide determin	ed 286. Place	e of Injury - At I ing, etc. <i>(Spec</i>	home, farm, sti :ify)	reet, factory, office		28f. Location (City or To			ural Route Number,	
	spital nours nerai / filled	a C	29a. Certifying	Physician: To the	bast of my kn	nowladge, deat	h occurred at the tir	ne, data and place,	and due to the	causa(s)	and manner as	stated.	
	he Ho in 24 in he Fu	edical	(Check only 2 Medical Ex	aminer: On the band man	asis of examin	ation and/or in	vestigation, in my o	pinion, death occur	rred at the time,	date and	place, and due	to the cause(s)	
	To To T	Σ	29b. Signature and title of certifier		20		29c. Licens				e signed (Mont		
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	12		30. Name and address of person we will be seen and address of person with the seen and address of the seen address of the seen and address of the seen and address of the seen and address of the seen and address of the seen address	, MO	3718	WORRIS	SVILLE R	D, SUITE	C, VAA	enet	TSVILLE	MD 2/084	
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	Registr	ar	SEP 112	UU/	3150 S.	S. JOSEPH	A STATE OF THE PARTY OF THE PAR						

Division or Vital Records, P.O. Box 68760,

Physician /Medical 4a. Facility Name (If not institution, give street and number) Examiner Union Hospital 5. Social Security Number **Funeral** Director 167-32-7856 Usual Residence of Decedent death with the Maryland 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director Maryland 10e. Street and Number 72 South Shore Road Funeral 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 ☐ Divorced Completed Elementary/Secondary (0-12) 17, Father's Name (First, Middle, Last) Be Thomas J. Lewis ၉ 19a. Informant's Name/Relationship (Type. Print) William H. McDaid/Son 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signat e of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi requires that the death certificate be execu attending physician Physician/Medical the as IF FEMALE: use 23b. Was decedent pregnant ō Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ sign be (page 2 should Completed certificate Physician: 25. Was case referred to medical examiner? Be ို 1 ☐ Yes this 27. Manner of Death Certification: or Attending After 5 ☐ Pending investigation 1 Natural 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065733 09/05/07 P. V. Naujau 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NARAYANA RAO V. PULA 1/2 NORT 118 NORTH STREGT SWITS, ELKTON, MD-21921 32 Registrar's Signature 31. Date filed (Month, Day, Year) Costs) Ellediss

Registrar

State of Maryland / Department of Health and Mental Hygiene 2007 amended item # 19B/8/30/07 Getti Patis of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2 355 M Virginia Hickernell Murray /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 4/10/1914 Birthplace (State or Foreign Country) **Funeral** Year) Days Months Hours Min 1 M 2 TXF 577-10-8169 93 Yrs Ohio Director Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits worke 1 XYes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1103 S. Schumaker Dr., Apt. 102 21804 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "naturel", or Item 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ₩Widowed 4 Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 labor Relations Officer U.S. Government f Health and Mental Hyg Item 27 le marked other other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell E. Hickernell Iona Marie Ruble ၉ 311 Manklin Creek Rd. Berlin D. 2 21811 19a. Informant's Name/Relationship (Type, Print) 501 Snow Hill Rd., Salisbury, MD 21804 Regan Smith/Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If Ite
eny injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory | 8/28/07 Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21801 Signature of Funeral Service Licensee CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Clostridium difficile **Physician** colitis resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ehydration 8/2 c/2005 Box 68760, Due to (or as/a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No Vital Hospital or Attending Physician: in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ŏ 28c. Injury at Work? Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred on 1 Natural 5 Pending investigation death. 2 No after death. 2 Accident Divisi 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a To the Funeral C 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. To the 29b. Signature and title of certifier 29c. License number Attendiona Name and address of person who completed cause of death (Item 23a) (Type Print) Stammas Drive C. Egora MD 9733 32. Registrar's Signature State 2007 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 27, **Physician** 2007 7:33 A M August Helen G. Mesa /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Mt. Airy Kline Hospice House If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F West Virginia July 20, 1925 82 Director 217-44-5725 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 1 X Yes 2 □ No Director White Sulphur Springs W. VA Greenbrier 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code an "natural", or items 23a or Medical Examiner must be 24986 United States 28 Pine Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 □ Yes XX No Specify: Specify: <u></u> XXWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ith and Mental Hygiene.
27 Is marked other than r traumatic event, the M 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Clarence Joseph 011ie Ramsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Gail Norman, daughter 4801 Green Valley Road Monrovia, Maryland

Physician /Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

	Exam
	Physician/Medical
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20a. Method of Disposition 1XXurial 2 □ Cremation 3 □ Removal from Stat	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	r Town, State
4 Donation 5 Other (Specify)	Alvon Presbyterian	09-01-07		West Virginia
21. Signature of Funeral Service Licensee	22. Name and Address of Fa			
1 Kint 1 Ct	1621 Opossumto			
23a. Par 1. Enter the Isea e, or plication the cause stock or heart file. ist only one couse or each	line.	1		Approximate Interval Between Onset and Death
Imm diat / Cause (Final di ease / condition a.	ONIC LYMPHOCYTIC	LEUKE	MIA	Onder and Death
resultin (in death)	s a consequence of):	-		
Secuentially list conditions b. +A	ILURE TO THRIL	ンピ		
if any, leading to immediate cause. Enter Underlying	is a consequence of):			
Cause (Disease or injury that initiated events c.				
resulting in death) Last Due to (or a	is a consequence of):			
d				
	ne pf pregnancy 2 Fetal death 3 Ectopic pregnancy		23d. Date of de	elivery Day Year

1 ☐ Yes 2 ☑ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

EMENTIA

1 ☐ Yes 2☐NO 3☐ Probably 4☐Unknown 24a. Was an performed 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

HD 21701

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

1 Inpatient 2 ☐ ER/Outpatient 28b. Time of 28a. Date of Injury (Month, Day Year) 5 Pending investigation

9☐Unknown

Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospice Hous 3□ DOA 28c. Injury at Work?

28d. Describe how injury occurred 1 Yes 2 No

29a. Certifier

27. Manner of Death

1 Matural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) -27.200

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOUSE AUE FREDERICK 814 TOLL SIBTE A KAZMI, MO

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 2 9 2007

6 ☐ Could not be

determined

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

24 hours after deatle Funeral Director:

within 2 To the I

State of Maryland / Department of Health and Mental Hygiene 2007

29100

			1 - For State Registrar	State of Maryla		rtificate of l			g. No.	7 29100
	Physici	an.	1. Decedent's Name (First, Middle,					Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Linda	Carmeli	ta	Maier		August	27, 2007	2044 M
	Examir	er	4a. Facility Name (If not institution,			4b. City, Town, or	4c. County of Dea			
	dağır v		WMHS-Memorial 5. Social Security Number	-	rs. last birthday)	Cumber If Under 1 Year	Land If Under 24 Hrs.	8 Date of Birth	Allega	ny thplace <i>(State or Foreign</i>
Ė	Funeral Director		219-44-0317 Usual Residence of Decedent	1□M 2\ F 61	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 01/09/1		yland
	nand ow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	the Mary 28a-f she	ector	MD Alle	gany		Cumberlar	ıd	146	og. Citizen of What Co	1 TYes 2 No
	ath with 1 s 23a or 3 nust be n	Funeral Director	1315 Bedfor			2	21502		USA	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? d 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:			white
5-6	72 h "natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	ing [16b. Kind of Business	/Industry
121	within ene. than	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	inte.				Home	
d 2	filed v Hygie other		12 17. Father's Name (<i>First, Middle, L.</i>	ast)	1	<u>Homemak</u>	18. Mother's Name	e (First, Middle, M		
lan	ld be ental ked o	To Be	Orlias	Glenn	McDoi	nald	Eva	1	/irginia	Hier
Maryland	should Mind Mind Mind Mind Mind	-	19a. Informant's Name/Relationshi	o (Type. Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Number,	City or Town, State,	Zip Code)
	and 2 alth a latter is 27 is		Donald C. Maier	s / Husband	1315	Bedford	Street, (Cumberlar	nd, Maryla	nd 21502
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	i i i removal from State		osition <i>(Name of matory or other plac</i> nd Cremat			20c. Location - City or Cumberlan	
Ħ	nit. Partme		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Juneral Service L							Home, P.A.
B	Dep lmp any		1 Librit C	· Cellen	I	04 Decatu			•	21502
	Physician /Medical Examiner		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that caused the donly one cause in each line. a	URAZ	ter the mode of dyin	g, such as cardiac		st, >	Approximate Interval Between Onset and Death
68760,	tificate be executed g physician and as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons c. Due to (or as a cons d.		// /				D/773
.O. Box	death cer e attendin id for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>	,		23d. Date of de Month	livery Day Year
rds, P	quires that n signed t	by	Part II. Other significant condition	s contributing to death but not	=	inderlying cause give	en in Part I.	23e. Did tob 1 □ Ye		o the cause of death? robably 4 ☐Unknown
Records,	has has	Completed	CERFBROV	ASCULA	RA	CCID	BMT	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
or Vital		Be C	25. Was case referred to medical examiner?				26. Place of Deat			2 2 140
<u>r</u> <	S S =	To E	1 Yes 2 No	Hospital: 1 ∏ Inpatient 2	□ ER/Outpatier	nt 3□ DOA Oth	er: 4 ☐ Nursing Ho	me 5 Reside	nce 6 Other (Spe	ecify)
o u	ng ffer inel		27. Mann eath 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Worl		28d. Describe ho	w injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Certification:	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 280 Place of injunt. A	t home, farm, str ecify)		M 1 ☐ Yes 2 ☐ No tt, factory, office 28f. Location (Street and Number or Ru City or Town, State)			ural Route Number,
	ne Hospita 124 hours ne Funera bletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best of my lixaminer: On the basis of examand manner stated.	knowledge, deat ination and/or in	th occurred at the tirn nvestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	Toth Vithii Toth comp	Ň	29b. Signature and title of certifler	2/ =7	///	29c. Licens		1	od. Date signed (Mon	
	5			mon	ann	3	54004	I I	August 28,	2007
	nes		30. Name and address of person w			Print) ional Hig	hway, La	Vale, Mar	cyland 21	502
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Sig	gnature			•		<u>_</u>
	negisti	ai .	DO W DOH	The state of the s	1. So	SAST.				

Physician /Medical Examiner

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Physician/Medical

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Medical Certification:

Department of H Important: If ite any Injury or ot once.

Physician

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Funeral

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Examiner must be notified at

Funeral Director

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

permit.

The law requires that the death certificate be executed

or Attending Physician:

the

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Sequentially list conditions, if any, leading to him what cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

24a. Was an

autopsy perform

29a. Certifier (Check only one)

30. Name and a 1r

examiner?

1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

20 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

HOSP DR

1 ☐ Yes 2 ☐ No

29b. Signature and

5 ☐ Pending investigation

6 Could not be determined

MD nerson who completed cause of death (Item 23a) (Type, Print)

Cheverly up 20785

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?

2□ No

1 ☐ Yes

State Registrar

31. Date filed (Month, Day, Year, AUG 29 2007

32. Registrar's Signature

DHMH 17 Rev 1/2001

3001

PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY S. Social Security Number 5. Social Security Number 102. State 103. State 104. CETY 105. Street and Number 4918 Ames St., N.E. 20019 11. Marital Status 12. Was Decedent Ever in U.S. 11. Was Decedent of Hispanic Origin? (Specify Yes or No- 11. Yes, 22th No 12. Yes and Post Number 12. Was Decedent Seducation 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 11. Yes, 22th No 11. Yes, 32th No 11. Yes, 32th No 12. Yes, Give Year or Dates. 12. Was Decedent Seducation 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 11. Yes, 22th No 11. Yes, 32th No 11. Yes, 32th No 12. Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 11. Yes, 32th No 12. Yes and No 12. Yes and No 12. Yes and No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Yes, Give 14. Yes,	2, 2007 8:30 a M County of Death PRINCE GEORGE'S 9. Birthplace (State or Foreign Country) Wash., DC 10d. Inside City Limits 1x Yes 2 No izen of What Country? aited States 14. Race - American Indian, Black, White, etc. Specify: Black ind of Business/Industry Private
4. Facility Name (I not institution, give street and number) 4. Facility Name (I not institution, give street and number) PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S HOSPITAL CENTER S. Social Security Number 5. Social Security Number 6. Sex Yr. 6. Sex Yr. 6. Sex Yr. 6. Sex Yr. 7. Age (in yr. last birrhday) 10c. City, Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 10d. City Town or Location 1	PRINCE GEORGE'S 9. Birthplace (State or Foreign Country) Wash., DC 10d. Inside City Limits 1x Yes 2 No izen of What Country? nited States 14. Race - American Indian, Black, White, etc. Specify: Black ind of Business/Industry
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Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location December Decedent December Decemb	10d. Inside City Limits 1 Yes 2 No izen of What Country? nited States 14. Race - American Indian, Black, White, etc. Specify: Black ind of Business/Industry Private
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Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death
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FFEMALE: 23c. If yes, outcome pf pregnancy 1 Yes 2 S No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Yes 2 S No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (specify) 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown 23c. If yes, outcome pf pregnancy 23c. If yes, outcome pf pregnan	23d. Date of delivery Month Day Year
1 Yes 2 (2) No 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacco use given in Part I. 23e. Did tobacco use	use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use given in Part I. 1 Yes 2 [24a. Was an	
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The second of th	
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28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 3 DOA 4 Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury	
1 St Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 1 Street and City or Town, State,	ad Alumber or Purpl Boute Alumber
27. Manner of Death Specified Part Par	d Number or Rural Route Number,)
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	te signed (Month, Day, Year)
	ugust 24, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie R. Bruce, M.D. 100 IrvingSt., N.W. Room EB3114 Wash	De 00010
State State Registrar ALIC 2 9 2007 ALIC 2 9 2007 State Registrar	h., DC 20010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Means Year Month **Physician** Craig August 4:50A M 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Riderwood Silver Spring Montgomery 6. Sex 7. Age (In yrs. last birthday If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Director 577-40-9104 Aug. 16, 1922 Louisiana Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 No Director MDPrince Georges Mitchellville Pages 1 and 2 should be filed within 72 hours after death with the nent of Health and Mental Hygiene.

Int. If item 27 Is marked other than "natural", or items 23a or 28a. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code an "natural", or items 23a or Medical Examiner must be r Funeral 1211 Kings Valley Drive 20721 U.S. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1942–46 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: African 1 ☐ Yes 2 X No þ 3 Widowed 4 Divorced American Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College of Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the 5+ Associate Dean, Dentistry Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Means Marie Washington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Patricia Means / Wife 1211 Kings Valley Dr. Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Sept. 4,2007 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. hompso 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastati **Physician** /Medical Due to (or as a consequence of): **Examiner** Urinari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Puthumana Loveen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVEEN J. PUTHUMANA, 3110 GRACEFIELD ROAD, SILVERSPRING, MD 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 2 9 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Miller Jr. 1:45 P^M William 26 2007 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Srping Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Days Hours 1 x M 2 □ F Jan 4 1923 Washington, DC Director 577**–**26–7048 84 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No Prince George's Glenarden Director Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20774 U.S.A. 9204 Beth Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Relocation Counselor Government 4 yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Brooks William Miller Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9204 Beth Avenue Glenarden, Maryland 20774 Agnes Miller/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Arlington Nat'l Ceme. 11/1/2007 | Arlington, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Europral Servi Licensee 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Epidural Abcess **Physician** /Medical Due to (or as a consequence of): Group B Streptococcal Sepsis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ing physician and as the burial-trans Pneumonia Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical Renal Failure IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by type 2 Diabetes Mellitus 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No Hypertension 24a. Was an page 2 autopsy performe Peripheral Vascular Disease 2K No certificate or Attending Physician: After this certification funeral director, I 25. Was case referred to medical 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 🔯 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours are dear the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ★ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 27/2007 Suparica Rom MD D0065485 bara 30. Name and address of person who come leted cause of death (Item 23a) (Type, Print) Supanich MD 1500 Forest Glen Rd Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

Registrar DHMH 17 Rev 1/2001

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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		1 - State Registrar			C	ertificat	e of L	Death		В	eg. No. 2	007	7 20105
Physici	an	1. Decedent's Name (First, Middle Claude E. M	e, Last) Mobley							2. Date of Dea	th	00 ^{Ygar}	3. Time of Death 1:00 A M
/Medic		4a. Facility Name (If not institution		ımher)		4b City	Town or	Location of I				nty of Deat	
Examin	er	Kensington Nur					sing				Montgomery		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthda	y) If Under	1 Year	If Under 24		B. Date of Birth	1	9. Birtl	nplace (State or Foreign
Director		251-01-7761	1 ₫ M 2□F	91	Yrs.	Months	Days	Hours	Min. J	Month, Day) 13 uly			ith Carolina
B .		Usual Residence of Decedent		10- 6	V. T.								
permit. Pages 1 and 2 should be lited within 72 hours after death with the Maryland Defined. The results and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	MD Mont	gomery		City, Town or	Spring							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
28a	Director	10e. Street and Number	gomery	53	LIVEL	10f. Zip	Code			1	Og. Citizen	of What Co	untry?
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ms 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in	U.S. 1:	3. Was Dece	lent of Hi	ispanic Origin	n? (Spec	fy Yes or No-	14. F	Race - Ame	rican Indian,
or Ite	Fu	1 ☐ Never Married 2 🔀 Mar	Armed F ried 1 X Yes If Yes, G	2 □ No		1 ☐ Yes		an, Mexican, I	Puerto R	ican, etc.)		Black, White	e, etc.
ral", Exal	d by	3 Widowed 4 Divorced	Year or I	Dates:		i Li tes	ZIXI NO	Specify:			Spe	ecify:	Black
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ntal ed ot	Be		Last)							orbits	maiden Suri	name)	
d Me mark mark	1	William Mobley 19a. Informant's Name/Relations	ohin (Time Brint)		10h Ma	ilina Addroso	(Ctroot				- City T-	04-4-	E- O- 4-)
d 2 s th an 17 is r traur		Barbara Johnso		r	121	30 Pon	d Pi	ne Dr.		Route Numbe	r, City or To	wn, State, 2	up Code)
Heal Heal tem 2		20a. Method of Disposition	21, - 11-6-1-2		Place of Dis	rksbur sposition (Nar	ne of	i	Da Da	te	20c. Location	on - City or	Town, State
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4		23a. Part Enter the disease, o	r complications that	caused the de						lashing respiratory ar		200	Approximate
lhisisa		show, or heart failure. List	t only one cause on	each line.						,	,		Interval Between Onset and Death
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w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Medical		d										
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arn ce ttend or use		23b. Was decedent pregnant in the past 12 months?	3 ⊑Ectopic pregnancy					23d.	Date of del Month	ivery Day Year			
the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unki	jnant at time of nown	f death :	5 ☐ Other (sp						MOITE	Day rear
d by	Physician	Part II. Other significant conditi	ions contributing to	death but not re	eulting in the	underlying c	auco aive	on in Port I		23e Did to	pacco neo c	contribute to	the cause of death?
res transigne	by	Part II. Other Significant Conditi	ions contributing to t	death but not re	souting in the	e underlying c	ause give	en in Fanti.					obably 4 □Unknown
requi	Completed	***			-				_		es 2 <u>M</u> N	0 3 1 1	———————
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cate , pag	Co										med? 24⊆ No	death? 1 ☐ Yes	2□ No
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this aldir	7	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 1 1	Inpatient 2	ER/Outpat	tient 3 DC		4 Es Nurs		e 5 Resid			cify)
aing After funer	ion	1 XNatural 5 ☐ Pendir	ng (Mo.	nth, Day Year)		y M	8c. Injur Worl	ya∖ k? Yes 2No		3d. Describe h	ow injury oc	currea	
death death ctor: y the	ical	3 Suicide 6 Could	not be	e of injury - At	home, farm,			163 2 110	_	Sf. Location (S	treet and N	umber or Ri	ural Route Number,
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spira nours neral / fille		29a. Certifier 1 ☑ Certifyi	ng Physician: To th	ne best of my k	nowledge, de	eath occurred	at the tir	ne, date and	place, a	nd due to the	cause(s) and	d manner as	s stated.
of the hospital of Attending Prysician: The law requires that the deam within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Medical	(Check only 2 Medical one)	I Examiner: On the	pasis of exami nner stated.	nation and/or	r investigation	, in my o	pinion, death	occurre	d at the time,	date and pla	ice, and due	e to the cause(s)
vithir To th	M	29b. Signature and title of certification				290	. License	e number			29d. Date si	gned (Mont	h, Day, Year)
		1 / SA	1 Kape	do			D078	31			Aug.	20, 20	007
(4)		30. Name and address of person		•									<u>-</u>
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Sta Registi		31. Date filed (Month, Day, Year, AUG 2 8 2007		Registrar's Sig		,							
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			For State Registrar	state of Maryland / Depa Cer	artment of Health and N rtificate of Death		ne No. 2007	29106
-	Physici		1. Decedent's Name (First, Middle, Last) Jack John Nolan			2. Date of Death Month August 24	Day Year	3. Time of Death 9:35 p M
* .	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give streethers County Nurs 5. Social Security Number 452-24-6648 6. Sex	·	4b. City, Town, or Location of Death		4c. County of Death Charles 9. Birthpl Coun.	lace (State or Foreign try)
If e, INTALYIGHTU ZIZID-UUDO 8 1 and 2 should be filed within 72 hours after death with the Maryland 6 Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Educat (Specify only highest grade of	1 2 Yes 2 □ No If Yes, Give Year or Dates: WWII ion 16a. December 16a.	ation 10f. Zip Code 20646 Was Decedent of Hispanic Origin? (Srif Yes, specify Cuban, Mexican, Puerton Company of the Compan	Decify Yes or No- o Rican, etc.)		an Indian, etc.	
II yidiiid Z IZ should be filed with nd Mental Hygiene marked other tha matic event, the fi		To Be Comp	Elementary/Secondary (0-12) G.E.D. 17. Father's Name (First, Middle, Last) Louis J. Nolan 19a. Informant's Name/Relationship (Type.	College (1-4or 5+) Supp	oly Procurment Chi	ief ne (First, Middle, Mai Nolan		
Daiminore, ma	permit. Pages 1 and 2 should Department of Health and Mer Important: if them 27 is marke any injury or other traumatic		Mary Boley-Daughter 20a. Method of Disposition 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	20646 c. Location - City or To Clinton, M pls Funeral a, MD. 2064	wn, State D. Home, P.A			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	- 4 - 5				Approximate Interval Between Onset and Death
ficate be executed physician and sthe burial-transit	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
O. DOX 0	the death certifi the attending p	hysician/Me	IF FEMALE: 23c 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
law requires that the death certific as been signed by the attending p	law requires that as been signed by 2 should be deta	Completed by Ph	Part II. Other significant conditions contri	buting to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac 1 Yes 24a. Was an autopsy	2 No 3 Prob	
ומוע	The ate h page	Be Com	25. Was case referred to medical examiner?			performe	d? death? (No 1 ☐ Yes	
VISION OF	at at	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	spital: 1 ☐ Inpatient 2 ☐ ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time o Injury 28e. Place of injury - At home, farm, str	of 28c. Injury at Work? M 1 Yes 2 No	y) Il Route Number,		
S	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by the		29a. Certifier 1X Certifying Physic	building, etc. (Specify) sian: To the best of my knowledge, deat r: On the basis of examination and/or in	th occurred at the time, date and place	City or Town,	State) use(s) and manner as s	tate d.
)	To the H within 24 To the Fi complete	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number 0.5.5.4.5	290	I. Date signed (Month,	
1	B 721		30. Name and address of person who com Fatima Hussein, MD	pleted cause of death (Item 23a) (Type, 5625 Allentown Rd.	100-7		1 20746	U /

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) 8 2007 32. Figistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** <u>11:</u>30₽ ^M 2007 ELIZABETH AUGUST NICKENS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🖫 F Yrs. 22 1922 84 Virginia 376-24-0167 **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 DKYes 2 □ No Director Washington D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Department of Health and Mental Hygiene "natural" or Items 23a or Important: If Item 27 is marked other than "natural" or Items 23a or yi njury or other traumatic event, the Medical Examiner must be a once. 20011 United States 4508 Blagden Ave., N.W. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. by 3 Midowed 4 Divorced Black Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Statistics Clerk Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F James E. Johnson Havana Johnson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4508 Blagden Ave., NW Wash., DC Avis C. Johnson / Daughter 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 13x Burial 2 □ Cremation 3 ☐Removal from State Lincoln Mem. Cemetery 9-1-07 Suitland, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Capitol Mortuary, Inc. permit. 21. Signa re of Funeral Service Licenses 1425 Maryland Ave., NE Wash., DC Approximate Interval Between Onset and Death complications that caused the death. 23a. Part 1. Enter the disease, o shock, or heart failure. Li Denot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS SYNDROME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician; The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🔀 No 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by CONGESTIVE HEART FAILURE DUE TO CARDIOMYOPATHY 1 Tyes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2**/XX**\0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2K No 1 🔼 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 23, 2007 D52261 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Segal, M.D. 1517 Hugo Circle 20906 Alan R. Silver Spring, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signatu AUG 2 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** O'STEEN AUG. 23, 2007 8:15 A MILDRED ARLINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CALVERT PORT REPUBLIC 2150 OAK RD. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months 1 ☐ M 21 F 78 20, 1929 MARYLAND Director 578-30-9697 APR. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic everal. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Funeral Director MD. CALVERT PORT REPUBLIC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2150 OAK RD. 20676 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🙀 No Specify: Completed by Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be В. GOSS MARION ROY BOTT ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) OAK RD., PORT REPUBLIC, MD. 20676 SHIRLEY CATLETT/DAUGHTER 2150 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHAMBERS CREMATORY 8-24-2007 RIVERDALE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lieensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 0 Immediate Cause (Final HEART 3 YRS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in inculate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENDL FAILURE CHRONIC 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed DIABETES 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

110 HOSPITAL RD., PRINCE FREDERICK, MD. 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

JUDGE, M.D.

CHARLES JU 31. Date filed (Month, Day, Year) AUG 2 7

				partment of Health and Nertificate of Death	Mental Hygiei		29109
	Physici	an	1. Decedent's Name (First, Middle, Last) Nelson Marshall Pittinger		2. Date of Death September		3. Time of Death 12:35 AM
7	/Medic Examin		4a. Facility Name (If not institution, give street and number) Citizens Care & Rehabilitation Center	4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
	Funeral Director		5. Social Security Number 215-09-6983 6. Sex 1½ M 2 F 91 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth May 6, 19	9. Birthpi Coun Mary	ace (State or Foreign toy) Land
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Frederick Freder				0d. fnside City Limits
	h with the 23a or 28a at be noti	al Director	10e. Street and Number 1497 West Ninth Street	10f. Zip Code 21702	_	Citizen of What Coun	try?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Importent: If Item 27 is marked other then "naturel", or Itams 23a or 28a-f ehow any injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 14 Yes 2 No 1942-1946 15 Was Decedent Ever in U.S. 15 Was Decedent Ever in U.S. 15 Was Decedent Ever in U.S. 15 Was Decedent Ever in U.S. 15 Was Decedent Ever in U.S. 15 Was Decedent Ever in U.S. 15 Was Decedent Ever in U.S. 15 Was Decedent Ever in U.S. 15 Was Decedent Ever in U.S. 16 Was Decedent Ever in U.S. 17 Was Decedent Ever in U.S. 17 Was Decedent Ever in U.S. 18 Was Decedent Ever in U.S. 19 Was Decedent Ever in	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Pueric □ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, of Specify: Whi	etc.
Baltimore, Maryland 21215-0036	l within 72 ho iene. r then "natur he Medicel I	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	sedent's Usual Occupation re kind of work done during most of work DO NOT use retired) e-President/ Manag	ring	. Kind of Business/Inc	lustry
land	uld be filed fente! Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Jesse Pittinger		e (First, Middle, Maid e Ne1son	den Sumame)	
Mary	nd 2 shoulth and N 27 is ma			iling Address (Street and Number or Run 6 Shookstown Road,			·
imore,	Pages 1 a nent of Hea ent: If Item ury or othe		20a. Method of Disposition 20b. Place of Disposition cametery, c.	position (Name of emalory or other place) National Cemetery Nov.		Location - City or To Fort Myer,	
Balt	permit. Departr Importe any Inju		21. Signature of Prograf Service Licensee MO0255	²² Kleeney dann Balsfor 106 East Church St	d PA Funei ., Freder:	ral Home ick, MD 21	701
8260, 8	Physician /Medical Examiner and burial-transit site burial-transit	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart faifure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	0 1.		ience.	Approximate Interval Between Onset and Death
P.O. Box 68	that the death certificate be executed ted by the ettending physicien and detached for use as the burial-transit	Physician/Medical		B⊟Ectopic pregnancy B⊟ Other (specify)		23d. Date of delive Month	ry Day Year
	law requires that as been signed b 2 should be deta	þ	Part ff. Other significant copditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death? abfy 4 ∐Unknown
Division of Vital Records,	The ate h page	Completed			24a. Was an autopsy performed	prior to cor death?	osy findings available inpletion of cause of No
<u> </u>	Physician: Th r this certiticate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	104 3	h (Check only one) ome 5□ Besidence	e 6 □Other (Specify	*)
ion of	ing Afte une		27. Manner of eath 1 Anaturaf 5 □ Pending (Month, Day Year) 1 Accident investigation 28a. Date of Injury (Month, Day Year)	of 28c. Injury at	28d. Describe how in		,
Divis	ital or Attand irs etter death rel Director: led in by the t	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnjury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	Route Number,
	To the Hospital within 24 hours e To the Funerel completely tilled	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de Medicaf Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and sine of certifier	29c. License number D-/397/		Date signed <i>(Month, I</i> eptember 4	
	12		30. Name and address of person who completed cause of death (Item 23a) (Typ Robert L. Kaufmann, M.D., 300 We		rederick,	MD 21701	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 1 2007	rle			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 11:45 AM Samue -07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPita, Silver Spring Under 1 Year | If Under 24 Hrs. | 8 N Prince 055 9. Birthplace (State of Foreign Country) 8: Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2□ F 70 39-48-9154 17,1937 Worthcarolina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show notified at 1 Tyes 2 No Funeral Director Georges Silver Sprina 28a-f with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or must be 20910 215 Stern Avenue 12. Was Decedent Ever in U.8. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be illed within 72 hours after d Heatth and Mental Hygiene. em 27 is marked other than "natural", or iten ither traumatic event, the Medical Examiner 1 ☑ Never Married 2 ☐ Married 1□Yes 2型No Specify Specify: Completed by Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Counselor Psychiatric-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be leanora nknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) R. 1207 H. 11 Rd. Landover, Maryland

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - C permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. *2078*5 Vardell Lamberson, JR. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethel 8/30/07 Cambridge, Maryland 4 Donation 5 Dother (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, P. A. HENRY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD. 21613 Immediate Cause (Final disease or condition resulting in death) Septic Shock **Physician** /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9 Unknown 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Fungemia, End Stage Renal Disease, Acquired 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has birector, page 2 s Immunodeficiency Syndrome, Malnutrition, Hypertension autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1

Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide

P.O. Box 68760, Division or Vital Records,

Maryland 21215-0036

Baltimore,

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier Luyanounden

29c. License number D53367

29d. Date signed (Month, Day, Year) August 23, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. Shyamsundar, M.D., 9801 Georgia Ave., Ste. 117, Silver Spring, MD 20902

State Registrar

Medical

			For State Registrar	State of Maryland / Dep Ce	artment of Health and N <i>rtificate of Death</i>		anec oor corr	
			1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death	ר
	Physicia /Medic		Ralph DAV	11 Palmer		Aug 2		М
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death		4c. County of Death FREDERICK	
			5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		8. Date of Birth	9. Birthplace (State or Fore	əign
	Funeral Director			M 2□F 79 Yrs.	Months Days Hours Min.	(Month Day)	1928 FREDERICK	to.
	D		Usual Residence of Decedent				10d. Inside Çity Lim	nite
	arylar show		10a. State 10b. County FREDER	10c. City, Town or L			1 2 Yes 2	
	the M	Director	10e. Street and Number	110000	10f. Zip Code	100	g. Citizen of What Country?	
	with with	급	SOO MOTTED	AVE -APT-501			C1. S. A.	
	ms 2	Funeral	11. Marital Status		Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.	
9	hours after death with the Maryland turel', or Items 23a or 28a-f show at Exercit per result by recitified at	E.	1 Never Married 2 Married	1 Pres 2 □ No	1 ☐ Yes 2 ☑ No Specify:	7 (1041), 5(5.)	Specify: RIALK	
5-003	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	edent's Usual Occupation	111	6b. Kind of Business/Industry	
7	in 72	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Giv-	e kind of work done during most of work DO NOT use retired)		55. (1.1.0 0) 515.1.7554 11.4151.)	
2121	filed within 72 Hygiene. other than "nater" and and ice	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	NOSCAPING	7.	PEE LAWN NURSERY	1
פ	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)	1 1 - 1	24	e (First, Middle, Ma	aiden Sumame)	
Maryland	should be nd Mental marked c	To	CHARLES C	, PAUNCE	MART	, , , ,	SEANER	
Jar	C	1 5	19a. Informant's Name/Relationship (Ty)	Bal	ing Address (Street and Number or Ru	ST- I-NE	7 .	
_	1 and Health em 27 Ither tr		20a. Method of Disposition	20b. Place of Disp	osition (Name of		Oc. Location - City or Town, State	
nor	Pages nent of int: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)		ematory or other place)	4287007	FRESERUL A	N
Baltimore,	nit. P vartme ortan injur.	i	21. Signature of Funeral Service Liver	99	22. Name and Address of Family	Ru L. Ro	LLINS FLOWERAL MOA	E
B	permit. Departr Imports any inj		Janey J. For		_ 7	,	1. Ms. 21701	
	**		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do not en	nter the mode of dying, such as cardiac	or respiratory arres	st, Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	Probable to	increatic can	100	Onsot and Dozali	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	5 1 15 0			
		-a	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	prostate con	(400	·	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
oʻ	exec en an	Exa	resulting in death) Last	Due to (or as a consequence of):				
8760,	icate be executed physicien and s the burial-transit	dlcai	•	l				
9		Med	IF FEMALE:	3c. If yes, outcome of pregnancy			22d Date of delivery	
Box	eath certific attending p	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year	
o.	that the deed by the detached	ysic	1 Yes 2 No 9 Unknown	9☐ Unknown				
۵.	requires that the death certific been signed by tha attending p hould be detached for use as	by Pt	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death'	?
rds	w require been sig should b	edt				1 🗆 Yes	s 2 100 3 Probably 4 Unkno	own
eco	aw 2 s	Completed				24a. Was an autopsy	prior to completion of cause	able of
E E	T ale	Con				perform 1 Yes 2	ned? death? □ No 1 □ Yes 2 □ No	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	Other	th (Check only one		
o	Physical direction	2	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Mursing H	ome 5 Resider 28d. Describe hor	nce 6 Other (Specify) winjury occurred	-
on	ding th. After fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	Attending r death. ector: After by the fune	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s	street, factory, office	28f. Location (Str. City or Town,	reet and Number or Rural Route Number,	
ā	tal or A	Certification	4 CITIOTHOUGH	building, etc. (Specify)		3.y 3. 10Wi		211
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exami	sician: To the best of my knowledge, de ner: On the basis of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the ca irred at the time, da	use(s) and manner as stated. Ite and place, and due to the cause(s)	
	To the h within 24 To the F complete	Medi	29b. Signatu e and title of certifier	and manner stated.	29c. License number	29	9d. Date signed (Mpnth, Day, Year)	
	Twit		250. Signature and title of certifier	A a si				
	MA		30. Name and address of person who co	ompleted suse of death (Item 23a) (Typ	e, Print)		(
4	610.		Hemen Shah no	65 c Thomas	DOOGOUI) o, Print) rohnson Dr. Er	ederick	-, MD 21702	

			1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H tificate of L	ealth and I Death		giene 2007	29112
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Mildred K. Pen	nington				2. Date of Dea Month August	Day Year 26, 2007	3. Time of Death 20:35 PM
	Examir		4a. Facility Name (If not institution, give st Sunbridge Nursing	treet and number)		4b. City, Town, or E1kton			4c. County of Deal	
	Funeral Director		5. Social Security Number 6. Sex 179-05-7027	7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) April 4	v, Year) Co	thplace (State or Foreign ountry) AWAYE
Maryland ZIZIS-0030	is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-1 show other treumatic event, the Medical Exercities must be neutified at	To Be Completed by Funeral Director	10a. State 10b. County Maryland Cecil 10e. Street and Number 34 Edgewater Avenu	e 2. Was Decedent Ever in U. Armed Forces? 1	16a. Deced (Give life. I Home	10f. Zip Code 21901 Nas Decedent of Hill 1Yes, specify Cuba 1 Yes 2 No dent's Usual Occupation of work done of 200 NOT use retired 2 maker	Specify: ation furing most of wor 18. Mother's Nar Maggie and Number or Ru	pecify Yes or No- o Rican, etc.) rking me (First, Middle, Crossan	Specify: When the state of Business of Swn Home Maiden Surname) or, City or Town, State, 2	Ces prican Indian, e, etc. nite /Industry
pailimore,	permit. Pages 1 an Depertment of Heal Importent: If Item 2 any injury or other <u>anges</u> .		Debra L. Penningto 20a. Method of Disposition 1XBurial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Private S rying L consistency 23a. Part 1. Enter the disease, or complications of the private S rying L consistency of the private S rying L consistency of the private S rying L consistency of the private S rying L consistency of the private S rying L consistency of the private S rying L consistency of the private S rying L consistency of the private S rying S	ations that caused the deat	Place of Disponementery, cremiter to 22	sition (Name of natory or other place) wwn Cemete . Name and Addres .7 South N	ery 29, ss of Facility C: Main Stre	pate 2007 rouch Fu eet, Nor		Town, State
0,00,	Centificate be executed from the puring physicien and from the puring-transit and the purin	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a consequence to (or a))).	uence of): uence of):					Onset and Death Ueans
O. BOX 0	death certifi e ettending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	lc. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
cords, r	requires that been signed hould be de	þ	Part II. Other significant conditions cont	nbuting to death but not res	ulting in the u	nderlying cause give	en in Part I.	101		obably 4 Junknown
שו שבכ	The lar ate has page 2	e Completed	25. Was case referred to medical					1 ☐ Yes	rmed? death? 2 No 1 Yes	utopsy findings available completion of cause of
7	Physicia rthis cert ral direct	To B	examiner?	ospital: 1 Inpatient 2	ER/Outpatien		er: 4 Nursing H	T .	ne) dence 6 □Other (Spe now injury occurred	cify)
IVISION	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifications)	Injury	M 1	k? Yes 2 □ No		Street and Number or R	ural Route Number,
3	Hospitel (24 hours a) Funerel Ditely filled i	edical Ce	29a. Certifier 1 Certifying Physical Control (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, deatl	n occurred at the time vestigation, in my of	ne, date and place pinion, death occu	e, and due to the	cause(s) and manner as date and place, and due	s stated. s to the cause(s)
1	To the within To the comple	Med	29b. Signature and gle of certifier			29c. License			29d. Date signed (Mont	* ' '
	() Sta	ate_	31. Date filed (Month, Day, Year)	mpleted cause of death (Item MD 1/8 32. Registrar's Signa	North S	+ Suite3	B, E	ekton!	MD 21921.	
	Registr	rar	AUG 2 8 2007	Marie D.	1000					

07-06576 Frank Arthur Pitt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 29113

			For State Certificate C	of Death	Reg. No.
	Physicia	ın/ 1	. Decedent's Name (First, Middle,Last)		2. Date of Death 3. Time of Death Month Day Year 0336 hrs
edica	al Examii		Frank Arthur Pitt	4b. City, Town, or Location of Death	August 25, 2007
		4	a. Facility Name (if not institution, give street and number) Pennsylvania Avenue @ Forrestville Road	Forrestville	Prince George's
			S. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	8. Date of Birth(MM/DD/YYYY) 9. Birthplace Glace of Foreign
	Funeral Director		579–13–0435 1XM 2 F 33 Y	Months Days Hours Min	August 30, 197 Country DC
Waster 49 1			Usual Residence of Decedent Oa State 10b, County 10c, City, Town or Loc.	ation	10d. Inside City Limits
	w any	- 1			1 Y Yes 2 No
	faryland 28a-f show I at once.	형	Maryland Prince George's District	10f. Zip Code	10g, Citizen of What Country?
	th the Maryland 23a or 28a-f sho notified at once.	Director	8107 Darcy Road	20747	United States
	ith th			Vas Decedent of Hispanic Origin? (S	pecify Yes or No- 14. Race - American Indian, Black,
	item ust be	Funeral	1 Never Married 2 X Married Armed Forces? If Yes 2 X No	Yes, specify Cuban, Mexican, Puerto	
	fter de [", or			Yes 2 X No specify:	Specify: Black
	atura	d by		ent's Usual Occupation (Give kind of most of working life. DO NOT use ret	
9	an "n	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 years	Union Employee	Steamfitter Union
003	filed within 72 Hygiene. d other than ', the Medical	Ĕ.	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
215-0036	de be filed within 72 hours at fental Hygiene. narked other than "natural event, the Medical Examin	Be C	Frank Pitt, Sr.		ra-Jean Smith
212	2 should be filed within 72 hours after death with the Maryland h and Menial Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	To B	19a. Informant's Name/Relationship (Type, Print)	ing Address (Street and Number or	Rural Route Number; City or Town, State, Zip Code)
Q.	permi Pages I and 2 should be file Department of Heafth and Menial H Important: If item 27 Is marked o injury or other traumatic event, Il		Olice I i i i i i i i i i i i i i i i i i i	C Larkspur Ct. W	
	Healt Healt		crematory of	osition (Name of cemetery, other place)	Date 20c. Location - City or Town, State
υOu	Pages ent of nt; I		4 Donation 5 Other Specify: Lincoln	Mem. Cemtery Se	ept. 1, 2007 Suitland, MD
Baltimore.	mit partm porta ury o	İ	21. Signature of Funeral Servi ich see 22	. Name and Address of Facility Ste	ewart Funeral Home, Inc.
<u> </u>	D ESETE		231 art I. Enter the disease, or complications that caused the death. In not enter	001 Benning Road,	NE Washington, DC 20019
	hysician /Medical		th ure. List only one cause on each line.	er the mode of dying, such as cardiac	Between Onset and Death
	_xaminer	5 8	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		
			h		
		ie	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	L.	19
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
	uted 1d ransit	EX	d		
	foo, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED		
69	cate by	Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery nancy Month Day Year
88	leath certific e attending for use as the	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregr	nancy Month Day Tear
Box 68760	death death le atter	Physician	1 Yes 2 No 9 Unknown g Unknown	Ottler (Specify)	
	at the de by the tached		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
٥	res that signed be de	d b			1 Yes 2 No 3 Probably 4 Unknown
200	v requir	Completed			24a. Was an autopsy findings available prior to completion of cause of
۲	eccone law te has the	티			performed? death? 1 Yes 2 No 1 Yes 2 No
<u> </u>	VICAL MEC ysician: The his certificate director, page	Be C	25. Was case referred to medical	26.Place of Death (Chec	
¥:5	VIC 1ysicis 1this ce 1 direc	0	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat		sing Home 5 Residence 6 🗸 Other: Scene
Oivicion of Vital Becorde	LIVISION OF VICAL RECORDS, F.O. BOX 801.00, within a Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	on: T	27. Manner of Death 28a. Date of Injury 28b. Time 1 Natural 5 Pending Aug 20, 2007 315 hrs		28d. Describe how injury occurred Passenger auto fixed object collision
	SIOI Atten death ector; by the	Certification:	2 Accident Investigation 28e Place of Injury - At home farm.		28f. Location (Street and Number or Rural Route Number, City
7	al or al or al or al Direction	<u>H</u>	Suicide Could not be determined (Specify) Major Road / Highly		or Town, State) Pennsylvania Avenue @ Forrestville Road, Forrestville ,
_	DIVISION DIVISION To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	2	29a. Certifier 1 Continue Physician: To the best of my knowledge, death of	ccurred at the time, date and place, a	and due to the cause(s) and manner as stated.
	thin 2 the 1 mplet	Medical	(Check only one) 2 Medical Examiner: On the Dasis of examination and/or inves and manuer stated.	tigation, in my opinion, death occurre	d at the time, date and place, and due to the cause(s)
	F 2 2 2 8	₹	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			XIV AVV	O.C.M.E.	August 25, 2007
10	(6)		30. Nav. an Andress of person who completed cause of death (Item 23a)	Danie Chanat Baltimana MD	21201
NL	10///	1	Susan Hogan MD. Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 2	21201
			31. Date filed (Month, Day 2007)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Powell **Physician** arleton August 3:55 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Hospital Johns Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Hours Min 68 Director 247-64-5644 March 1,1939 South Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 □ No Director Va. Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or dical Examiner must be r 2 Potomac Court Funeral 22314 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 TYes 2 ☐
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married 2 ☐ No 1 ☐ Yes 2 ☐ No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Government 5+ marked other Judge 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fil Health and Mental H tem 27 Is marked ott Be Ralph Carleton Powell Caro Cleveland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Powell/ Wife Potomac Ct., Alexandria, Va., 22314 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Important: I any injury o Ivy Hill 8/29/2007 | Alexandria, Va. Cemetery 22. Name and Address of Facility Everly Wheatley Funeral Home 21. Signature of Juneral Service Licensee 1500 W. Braddock Rd, Alexandria, Va. 22302 MO 1453 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 Car Immediate Cause (Final Acute Myelord lenkenia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1 week Preumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Squamovs Cell carringmang tougue The law requires that the death certificate be executed Exami 5 months burial-trar Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 🔭 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this Manner of Death

Division or Vital Records, P.O. Box 68760, or Attending within 24 hours after death To the Funeral Director: filled in by completely

Maryland 21215-0036

Baltimore,

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joanna M. Peloquin, M.D. 600 North Wolfe Street, Baltimore, Moryland 21287 31. Date filed (Month, Day, AUG 2 8 2007

29b. Signature and title of certifier

1. Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

5 ☐ Pending investigation

6 Could not be determined

32. Registrar's Signature

Danna M. Keloquen, Doctor

28a. Date of Injury (Month, Day Year)

Registrar

After 1

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Medical

Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

August 23, 2007

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Pratt Aug 8, 2007 Dominic Vincent 9:50 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13708 Cecil Avenue Allegany Cresaptown 8. Date of Birth (Month, Day, Year) Jul 23, 1922 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Months Min. Hours Director 215-16-4470 85 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at MD Garrett Swanton Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 South Shore Drive 21561 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio Specify. ģ Specify: 3 ☑ Widowed 4 ☐ Divorced white Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than " Elementary/Secondary (0-12) 12 College (1-4or 5+) Coal Miner Local 1444 UMWA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H is marked ot Michael Pratt Josephine (Pascuzzi) Pratt Pages 1 and 2 should nent of Health and Men traumatic ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Thomas Pratt brother 13701 Cecil Avenue Cresaptown MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ X remation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 8/9/2007 MD 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown 21. Signatur of Juneral Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Fard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im diate Cause (Final disease or condition realting in death) **Physician** UNG /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 6 Nother (Specify) SISTER Other: 4 \(\text{Nursing Home} \) 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 🗌 Residence Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural Injury 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 after death Director: 24 hours a To the within 2

12 TILS

DHMH 17 Rev 1/2001

31. Date filed State Registrar

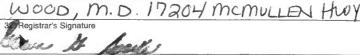
Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

LISON_EVANS 1 2007



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

40656680

29d. Date signed (Month, Day, Year)

21505

PTOWN, MI

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 the Hospital

Baltimore, Maryland 21215-0036

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 📂 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifig Balon, D.O 29c. License number 29d. Date signed (Month, Day, Year) ATZ438946-HZ August 30, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Memorial Hospital Baron 0,0 Union Matthew S.

State Registrar

Medical

31. Date filed (Month, Day, Year) 1 1 2007



20

		State of Mary 1- State Registrar Amend #12 Per Inf 0871 9/19/0	land / Depa Элтн <i>Cer</i>	rtment of Health and tificate of Death	Mental Hyg	iene 2007	29117
Physic	ian	Decedent's Name (First, Middle, Last)	07 G11		2. Date of Deat Month		3. Time of Death
/Medi	cal	JAMES 4a. Facility Name (If not institution, give street and number)	RIL	EY 4b. City, Town, or Location of Deat	09	03 2007 4c. County of Dea	1542 M
Exami	ner	WMHS-BRADDOCK CAMPUS		CUMBERLAND	11	ALLEGANY	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In 1 Number 214-28-6373	yrs. last birthday). Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Oct 4, 1	Yea <i>r</i>) 9. Bir	thplace (State or Foreign ountry)
D		Usual Residence of Decedent				323	
e Marylaı la-f show tified at	ctor	MD Allegany	c. City, Town or Loc Cum	berland			10d. Inside City Limits 1 Yes 2 No
th with th 23a or 28 ust be no	al Director	10e. Street and Number 1102 LaFayette Avenue		10f. Zip Code 21502	10	Dg. Citizen of What Co USA	ountry?
Mid yidilid Z i Z i 3-0030 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	y Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No □ If Yes, Give W	Kompa	Vas Decedent of Hispanic Origin? (Si Yes, specify Cuban, Mexican, Puer Yes 2 No Specify:	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify:	te, etc.
2 hours	ed by	15. Decedent's Education	16a. Deced	ent's Usual Occupation		16b. Kind of Business	hite
LIST TEND TO THE TRANSPORT OF THE TRANSPORT OF THE TRANSPORT OF THE THE TRANSPORT OF THE THE THE THE THE THE THE THE THE THE	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done during most of wo OO NOT use retired)	rking	201	
filed wit Hygien other the		12 17. Father's Name (First, Middle, Last)	mach		me (First, Middle, N	CSX Maiden Surname)	
allyially Should be and Mental is marked o	To Be	Gerald C. Riley			C. (Allen	,	
		19a. Informant's Name/Relationship (Type. Print) James Riley son	19b. Mailin	g Address (Street and Number or Routh Woodlawn	ural Route Number, LaVa		Zip Code) MD 21502
2 2 2 2 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Ob. Place of Dispos cemetery, cren Hillcrest Mer	sition (Name of natory or other place) norial Park	Date 9/7/2007	20c. Location - City or Cumberla	
permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	22	Name and Address of Facility Scarpelli Funeral Ho 108 Virginia Avenue		d, MD 21502	
Physician /Medical Examiner	Examiner	2 1. a.m. Enter the disease, or complications that caused the structure, or heart failure. List fully one cause on each line. Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	nsequence III	_ A	c or respiratory arre		Approximate Interval Between Onset and Death
ficate be executed in physician and streets the burial-transit.	edical Exa	that initiated events resulting in death) Last C. Due to (or as a column of the	nsequence of):				
ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3□	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
w requires that the de been signed by the s should be detached t	by	Part II. Other significant conditions contributing to death but no	t resulting in the un	derlying cause given in Part I.		acco use contribute to	o the cause of death?
	Completed				24a. Was ar autops perform	y prior to	utopsy findings available completion of cause of
sician: The certificate irector, pag	Be C	25. Was case referred to medical examiner? Hospital:		Othori	ath (Check only one		
at this	7: To	27. Manner of Death 28a. Date of Injury	2 ER/Outpatien	Other: 4 Nursing F	lome 5 Reside	nce 6 Other (Spe	cify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	Certification:	1	At home, farm, stre	M 1 ☐ Yes 2 ☐ No	28f. Location (St. City or Town	reet and Number or R , State)	ural Route Number,
e Hospita 24 hours e Funeral etely fillec	Medical C	29a. Certifier (Check only one) 1 Certifying Physic: To t best of my cone and anner stated.	y knowledge, death mination and/or inv	occurred at the time, date and plac restigation, in my opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
To the vithin To the complex	Me	29b. Signature and title of certifier		29c. License number	25	9d. Date signed (Moni	th, Day, Year)
	9	1 [/hy/		1000 36761	/	Jeptemb.	er 4,2007
10		30. Name and address of person who completed cause of death UK Ramadity a Poonai	(Item 23a) (Type, I	29c. License number DOU 3676	Drive,	Cumberla	and, Mary last
Sta Regist		31. Date filed (Month, Day, Year) 7 SEP 1 1 2007	Signature	W.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Auqust 2007 **Physician** 11:30 PM Paul William Rodeffer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hagerstown 908 Fairview Road If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) NOV 14 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 80 219-20-1897 1926 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show eny injury or other traumatic event, Ita Medical Examinating recitifical at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No Washington Hagerstown Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21742 908 Fairview Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 2 Yes 2 No 11-29-44 If Yes, Give Year or Dates: 7-24-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Pangborn Corp. Shipping Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ruth Elizabeth Mowen Charles Franklin Rodeffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 Fairview Road Hagerstown Maryland 21742 Lois M. Rodeffer 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 8-30-2007 Smithsburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease of combileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Omonth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed Was an autopsy performed? 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificata 1 Yes funeral diractor, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide Funeral 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 24 4+K MDo 32. Registrar's Signature 31. Date liled (Month, Day, Year) State AUG 29 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2;13PM e /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic HOSDI +al 7. Age (Infyrs. last birthday) TCNOTO CESTOR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214-26-943 Days Hours Min 1□M 20 F Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f show any follury or other treumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 18 12. Was Decedent Ever in Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jeorgia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) arvin CILIN 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 28-07 Va 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility nic Smith foresol Ban 917 W. Frabella Street Sallibury, n 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Stapl Immediate Cause (Final **Physician** aureus Septreemia 10000005 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner -110 Decubi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner for use as the burial-transit The law requires that the death certificate be executed Pulmonary Disease Obstructive that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical truct Urinary IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? funeral director, page 2 should be Failure 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an After this certificate has Vital 1 Yes 2 No 1 Yes 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 643 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, Jarm, street, Jactory, office building, elc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40064428 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person with

Registrar

State

Healthway Drive

9733

32 Registrar's Signature

ymala

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 29120 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Phillip Lee Robbins, Jr. August 1759 M 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ambrida Dorchester If Under 1 Year | If Under 24 His Months | Days | Hours | Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 1X M 2□ F 53 216-64-8714 10,1954 Aug. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6416 Suicide Bridge Road 21643 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steam Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip Lee Robbins, Sr. Emma Jean Morgan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald W. Robbins/Son 6416 Suicide Bridge Road, Hurlock, MD 21643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 8/23/2007 Delmar, Delaware 21. Signature of Fun ^{22. Name and Address of Facility} Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Muocordia Due to (or as a consequence of): orona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? 1 Xes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

f than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

and 2 should be filed is marked other

and Mental

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.

burial physician as nse for L page 2 should certificate l this

Physician/Medical

þ

Completed

Be

Certification: To

funeral director, After within 24 hours after death To the Funeral Director: filled in by the

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

1 ☐ Yes 27. Manner of Death 1 Natural

29a. Certifier

(Check only one)

25. Was case referred to medical examiner?

3 ☐ Suicide

6 Could not be determined 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 200

21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRENDON PALTOO Aurora 05

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Re trar's Signature

State

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien 2 1 1 7

20121

		-	For State Registrar	State of Man		rtificate of			Reg. No.	001	
龙	Physic /Medi		1. Decedent's Name (First, Middle, Las John V. Reidy	7				2. Date of De Month Aug.	20 Day	200 ^{Year}	3. Time of Death 1:52 pm
	Examir	ner	4a. Facility Name (If not institution, given Washington Adver	·	al	4b. City, Town, Takoma			Mo	ntgomery	
£, (₹	Funeral Director		5. Social Security Number 6. S 577-28-9424 Usual Residence of Decedent	FTM OFF	n yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days		8. Date of Bir Month, Da Mar • 2	$\frac{1}{2}$ 6, $\frac{1}{2}$	9. Birthp Cour 924 Wash	place (State or Foreign Dington DC
	how		10a. State 10b. County	10	Dc. City, Town or Lo					1	0d. Inside City Limits
	8e-fs	Director	DC none		Washingt						1 X Yes 2 No
	ath with the 23s or 2	ral Dire	10e. Street and Number 4437 Yuma Stree			10f. Zip Code 2001			US	zen of What Cour	ntry?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23e or 28e-f show amounts if Item 27 is marked other than "natural", or Itams 25e or 28e-f show any jury or other traumatic event, the Madical Eventral member notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ Nor If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cui	Hispanic Origin? (Spoan, Mexican, Puerto o Specify:	ecify Yes or No Rican, etc.)	o-	14. Race - Americ Black, White, Specify: Whi	etc.
<u>ဂ</u>	"natu	Completed	15. Decedent's Ec (Specify only highest gra	ducation ade completed)	16a. Dece (Give	dent's Usual Occu	pation during most of worked)	ang	16b. Ki	nd of Business/In	dustry
7 7	iene r than	omp	Elementary/Secondary (0-12)	Colfege (1-4or 5+)			Engineer		Walt	er C. Do	oe Co.
Maryland ZIZIS-0036	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Michael Patrick				18. Mother's Nam Catheri	e (First, Middle .ne Corl		Sumame)	
Mary	nd 2 shorath and h		19a. Informant's Name/Relationship (**Colleen Truhe			_	vand Number or Rui		-		
baitimore,	Pages 1 and 2 ent of Health a nt: If Item 27 is y or other trait	,	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	20b. Place of Dispo cemetery, crer Gate of I	sition (Name of matory or other pl Heaven Ce	emetery 8/	Date 24/2007	20c. Lo	cation - City or To	ng, MD
E E	Departm Departm Importar any injui		21. Signature of Funeral Service	77	22	2. Name and Add	ess of Facility De	Vol Fur	neral	Home	
	40 = € Ø		23a. Part1. Enter the disease, or com	1 ply			consin Ave			n DC N.	Approximate
	Pnysician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	onsequence of);	AZXOP					Interval Between Onset and Death
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of):	ENTH	XSEMA				
00/00	tificate be executed ig physicien and as the burial-transit	edical E	(d	onsequence or,						
7.0. DOX	The law requires that the death certificate be executed tie has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of a 1 □ Live birth 2 □ 4 □ Pregnant at tim	Fetal death 3	Ectopic pregnan Other (specify)	су		1	23d. Date of delive Month	ery Day Year
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2	aw requir is been si 2 should	Completed by	RENAL INSU					24a. Was		24b. Were auto	ppsy findings available
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\ !!a	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospitaf		10	26. Place of Deather:				
5	Physic this stal di	To To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Y	2 ER/Outpatier	1 00 DOX	4 (110131119 r l	ome 5 Resi		6 Other (Specific occurred)	(y)
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funarel Director: After th completely tilled in by the tuneral	edical	(Check only 2 Medical Exam	nysician: To the best of n niner: On the basis of ex and manner stated	amination and/or in						
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			30. Name and address of person who TASNEEM MAL	TK 7600	h (Item 23a) (Type,		DE TAI	TOMA		K HD:	
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			1 - For State Registrar	State	of Marylan	d / Depa <i>Cei</i>	artment of H	lealth and N Death		giene 0	07	29122
			Decedent's Name (First, Middle, Li	ast)					2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia	_	Nancy Louise	Rice					August	,	2007	2:10 PM
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and nu	ımber)		4b. City, Town, or	Location of Death		4c. County	of Death	
			100 Grayson Aven					ake City		Cec		
Н	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 1□M 20XF	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl	y, Year)		ace (State or Foreign try)
	Director		202-38-3203 Usual Residence of Decedent		59	113.		<u> </u>	Jan. 2	2, 1948	Penn	sylvania
	land ov		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits
	Mary	ţ	Maryland Cecil		Che	sapeak	e City					1X1Yes 2□No
	h the	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of \	What Coun	try?
	15 wit	a	100 Grayson Aver	nue Apt	302		219			United S		
	within 72 hours after death with the Maryland ene. Then "naturel", or iteme 23a or 28e-f ehow he Madical Examiner must be motified a	Funeral	11. Marital Status	Armed F		.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S) an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Rac	e - America ck, White, e	
9	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ XDivorced	1 ☐ Yes If Yes, G Year or I	2X No ive		1 ☐ Yes 2X No	Specify:		Specify	Wh:	ite
0-00-c	hour		15. Decedent's 1		Jates.	16a, Dece	dent's Usual Occup	ation		16b. Kind of B	usiness/Ind	lustry
<u>0</u>	iin 72 n "ne natio	Completed	(Specify only highest g	rade completed		(Give	kind of work done DO NOT use retired	durina most of wor.	king			
7	yiene.	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)	Certi	fied Nurs	sing Assi	stant	Healt1	ncare	
and	othe vent,	Bec	17. Father's Name (First, Middle, Las	t)				18. Mother's Nan			18)	
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la ₁	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "naturel; or iteme 23a or 28e-f ehow any injury or other traumatic event, the Maulical Examinat must be mailtied at ance.		19a. Informant's Name/Relationship Kristina Sherman		stor		ng Address (Street					Code) ry1and21901
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<u> </u>	troff trife or ot		20a. Method of Disposition 1 □ Burial 2X□Cremation 3.		ا القاضا		natory or other place					
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a D	Depa Depa Impo any ir		21. Signature of Pilitary Salvice Co.				2. Name and Addre					ru1nand2100
		_	23a. Part1. Enter the disease, or co	mplications that	caused the deat		ter the mode of dyir				l, Ma	ry1nand2190 Approximate
			shock, or heart failure / List on Immediate Cause (Final	y one cause on	each line.							Interval Between Onset and Death
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Ď,	e exe ien a urial-t		resulting in death) Last	Due to	o (or as a conseq	uence of):						
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o	the de	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk		19411 3						
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Š	Attending r death.	atic	2 Accident investigat	h-				Yes 2 No				
DIVISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Hornicide determine	208. Flat	ce of Injury - At h ding, etc. <i>(Speci</i>	ome, farm, st fy)	reet, factory, office			(Street and Num wn, State)	ber or Rura	al Route Number,
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	Hos Pur 4 Pur 9	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	aminer: On the	ne best of my kno basis of examina Inner stated.	ation and/or in	th occurred at the ti nvestigation, in my	opinion, death occi	urred at the time	, date and place,	and due to	the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29h Signature and title of certifier				29c. Licen	se number		29d. Date signe		Day, Year)
)	F>F0		1 Anhain	a 1	wo.	ws	Do	25915		8	2)-	0)
	2		30. Na e and address of person wh	o com ⇒ted ca	use of de h (Ite	m 23a) (Type	, Print)	.0/-	- 1	0160		
	9		30. Na e and address of person what the state of the stat	Him S	treet s	Suite	312	GUERN	MI C	21721		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2017 29123 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 25^{Day} 2007 ear **Physician** 9:00 P M Mayer ROTHMAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 205 Hermleigh Road 8. Date of Birth (Month, Day, Jan. 1, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Sex 1□M 2□F **Funeral** Days Hours 1910 Poland 97 086-26-6175 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 22 any injury or other traumation. United States 20902 205 Hermleigh Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Specify: ò 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dressmaker Clothina 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raiza Berman Mordechai Rothman P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 Hermleigh Road, Silver Spring, MD Esther Rozmaryn, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 08/27/07 Queens, NY Montefiore Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funery Service Leason

254 Carroll St., NW, Washing

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line.

Renal Disease Form Miskyss Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Closease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed?

1 Yes 2 \(\bar{\Delta}\)No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work?

be executed P.O. Box 68760 Division or Vital Records,

Baltimore, Maryland 21215-0036

funeral director, s after death. death. filled in by ō within 24 hours a To the Funeral I Hospital completely

1 🗀 Natural 2 Accident 3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signature and title of certified

29a. Certifier

5 Pending investigation 6 ☐ Could not be

and manner stated.

1 ☐ Yes 2 ☐ No

29c. License number

D09834

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) August 26, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry N. Rosenbaum, 3720 Farragut Ave., Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year) 2007 AUG



To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 7

			1 - For State Registrar	State of Ma		ertificate of I		nental Hy	giene U	01 29124
П	Physici	an	Decedent's Name (First, Middle, Las	,				2. Date of De	ath Day	3. Time of Death
	/Medi	cal	Ernest Paul Straw					Auglen		007 6394 M
	Examir	er	4a. Facility Name (If not institution, give				Location of Death	. 0	4c. County	
	-	0	Harford Memorial + 5. Social Security Number 6. Se		(In yrs. last birthday	Havre de		O Data of Siz	Harfor	
	Funeral Director			M 2□F	82 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Aug. 1	W Veer	9. Birthplace (State or Foreign Country) Pennsylvania
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Madical Examinat must be notilised at once.	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Ne M	Director	Maryland Harford		Havre de	•				1 ☐ Yes 2 🕱 No
	with t	Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	leath	Funeral	1737 Bryan Rd.	12. Was Decedent E	ver in U.S. 13	21078	reasis Origin? (So		U.S.A.	American India
(0	r iten	Fun	1 ☐ Never Married 2 🕅 Married	Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black	e - American Indian, k, White, etc.
8	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	° 1943- 1946	1 ☐ Yes 2 🖔 No	Specify:		Specify.	White
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and	ntal H	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		. Maiden Sumam	9)
Ž	should nd Men marke umatic	ဥ	Stephan Strauss 19a. Informant's Name/Relationship (T)	una Print	405 14.3		Anna Ker			
Maryland	d 2 s Ith an R7 ian		Opal Strauss (Wind			ing Address (Street a				
ē,	Health tem 27 other tr		20a. Method of Disposition		20b. Place of Disp	Bryan Rd.		e Gruce		City or Town, State
90	Pages nent of int: if it		1 X Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,			matory or other place ไอท Gando		12007		. Maryland
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licens							Funeral Home
Ö	Depa impo any i		1 Tara C.	Zelln						ce, MD 21078
			a. Part1. Enter the disease, or companies shock, or heart failure. List only of	ications that caused	the death. Do not en	ter the mode of dying	, such as cardiac	or respiratory ai	rrest,	Approximate
Ì	Physician /Medical Examiner		Immediate Cause (Finaf disease or condition resulting in death)	MALIGNANT	/	NOID	Tume	RI		Interval Between Onset and Death
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.O. Box	The law requires thet the death cert ite has been signed by the attending page 2 should be detached for use	by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1⊟Live birth 2 4⊟Pregnant at t 9⊟ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	o of delivery th Day Year
۹.	thet	Y P	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
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on of	Attending Physician: or death. ector: After this certific by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time o	f 28c. Injury Work			ow injury occurre	
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á	호육급도	Cert	4 Homicide determined	building, etc.	(Specify)	ou, tastery, emoc		City or Tow	m, State)	or riara riozio reaniber,
	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by	Medical	29a. Certifier 1 Certifying Phy: (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	exammation and/or in	h occurred at the time vestigation, in my opi	e, date and place, a inion, death occurre	and due to the ded at the time, d	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
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5	+1		30. Name and a ress of person who co	mpleted cause of dea	ath (Item 23a) (Type,	Print)	01-	1	Jugasi	22 2007
			31. Date filed (Month, Day, Year)	UN102	AVENUE,		CH UTCH	2 19	P	
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State of Maryland / Department of H	Health and Mental Hygien 2007	29	125

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	/Medi			a T. Sav							Septen	nber 1,	2007	7:32 P	ММ
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	Funeral Director		214-22-4382	Sex 1 □ M ② CXF	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Feb. 9,	th 191 6	9. Birthi Peni	olace (State or F ntry) nsylvan:	ia
	e Maryland 3a-f ehow	ctor	Usual Residence of Decedent 10a. State Maryland Treder:	ick		City, Town or Lo Frederi								0d. Inside City 1 X Yes 2	
	th with the	Funeral Director	10e. Street and Number 917 Shawnee Dri	ive			10f. Zip	Code 2170	1			10g. Citizen o		ntry?	
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	and 2 sho ealth and n 27 le m		19a. Informant's Name/Relationship (Fred E. Thaete)			917	Shawr	nee 1			Route Numberederick			Code) 21701	
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DIVISION	al or Attendi s after death. I Director: A id in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place	of Injury - At I	nome, farm, stre	eet, factory,	, office		2	8f. Location (S City or Tow	Street and Num m, State)	ber or Rura	Route Number	r,
	To the Hospital or Attentwithin 24 hours after deati To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Pr 2 Medical Example	miler. On the bi	best of my kn asis of examin ner stated.	owledge, death ation and/or inv	occurred a estigation,	at the tim	e, date and pinion, deat	d place, a	nd due to the o	cause(s) and m date and place	nanner as st	ated. the cause(s)	
	To the within To the Comp	Ň	29b. Signature and title of certifier	m.	D.		29c.	License	number 540	36	,	29d. Date sign	ed (Month,	Day, Year)	1
	50		30. Name and address of person who	completed caus	e of death (Ite	m 23a) (Type, 8	Print)	lair	of) ip	Fred	enich	< M	1.217	01
	Sta Registr		31. Date filed (Month, Day, Year)	107	egisikar's Sign	ature	de	1411		,,	1		17		-1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a, b, c, e, f, per fh 9871 9-21-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 30-2007 08 Smith Thelma /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frostburg Allegany WMHS-Frostburg Nursing & Rehab 9. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) Aug 26, 1922 Social Security Number 7. Age (In yrs. last birthday) Under 24 Hrs. 6. Sex **Funeral** Hours Days 1 ☐ M 2 ☐ F Min 214-14-9458 Director 85 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Allegany rai", or items 23a or 28a-f show Examiner must be notified at Frostburg --Worcester Ocean Pines 1 Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 48 21532 Tarn Terrace -21811USA Be Completed by Funeral I 789 Ocean Parkway 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify 3 ☑ Widowed 4 ☐ Divorced white "natural", permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygene. Important: If Item 27 is marked other than "naturaly injury or other traumatic event, the Medical than 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bureau of Land Acquisition 12 Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adelaide R. Miller Crismer James W. Crismer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 daughter 5 Sunset Drive LaVale M. Kathryn Burkey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/1/2007 Scarpelli Funeral Home, P.A. MD Cresaptown 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service License 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 5.11. Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final cardio vascular **Physician** Atherosclerotic disease or condition resulting in death) 6month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy 2 **Z**No 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No М 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) worked stin 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 48 Twon Terrace Frostburg MV 21532 SHIN WONSOCK 31. Date filed (Month, Day, Year) SEP 1 1 2007 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Wayne Sturgill 2007 Emory 31, 9:53 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 219-56-3711 54 Jan. 26, 1953 Maryland Director Usual Besidence of Decedent 10d Inside City Limits 10c. City, Town or Location show r 28a-f show notified at 1 ☐ Yes 2 X No Director MD Baltimore Cockeysville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number r than "natural", or items 23a or the Medical Examiner must be 8 Bridge Lake Circle 21030 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Refuse 12 should be filed w n and Mental Hygier ' is marked other th injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emory Sturgill Mildred B. Mullins 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau Patricia A. Sturgill/Wife 8 Bridge Lake Circle Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5, Sept. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Wiseburg Cemetery White Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licen Much W. 24 Second St. New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Un Known /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Vulmonan Fi prosis Completed COPD 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed? 1□ Yes 2☑ No Heart Congeitore Farmere director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, Division or Vital Records, Hospital or Attending Physician: after death 24 hours a Funeral I

within 2

Medical

29a, Certifier

29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC 6701 North Charles Street J CGreenawelt, M.D. 32. Registrar's Signature

2007

Year) 11

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and manner stated.

🚧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0060248

29d. Date signed (Month, Day, Year)

August 31, 2007

Bullmore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 () () 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gladys Louise Schaefer 07 30 2007 1735 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Easton Talbot Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 1 □ M 2 🔀 F 80 Yrs. 154-20-9358 Director March 24, 1927 New Jersey Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 XNo Maryland Directo Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26144 Sennett Road 21629 United States of America Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. the Medical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ō Specify: Caucasian þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Home Pages 1 and 2 should be filed an nent of Health and Mental Hygicint: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Merton Bunn Anna Louise Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Schaefer husband 26144 Sennett Road, Denton, Maryland 21629 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6 permit. Page Department c Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetary 8/3/2007 Denton, Maryland 21. Sanature of Funeral Service Licensee 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Mary and 21629 23a. Part1. Enter the disease, or con shock, or heart failure. List only complications that caused the death. Do not ente Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Se (or as a consequence of): /Medical Examiner stra Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine law requires that the death certificate be executed physician and s the burial-trans Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ icate has been sig ; page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed 1 Yes 2 No 1 ☐ Yes 2 No Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA funeral dir After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 Pending To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature;and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Easton, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

Haider A Sarraf M.D

D59762

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7/31/07

Au Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. City 4d. C	2007 29129
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. City, Town, or Location of Death 4c. City, Town, or Location of Death 4c. City, Town, or Location of Death 4d. City, Town, or Location of Death	3. Time of Death 8 2007 8:55AM M
Washington County Hospital Hagerstown Washington County Hospital Hagerstown Washington County Hospital Hagerstown Managerstown Managers	8 2007 8:55AM M
5 Social Security Number 6 Sev 7 Ang (In vrs. last hirthday) If Under 1 Year 1 If Under 24 Hrs. 8 Data of Birth	Washington County
1 DM 2 AF Nonths Days Hours Min. 1 (Month, Day Year)	9 Birtholace (State or Foreign
Director 217-28-6935 1 M 2 AF 74 Yrs. World Days 1 July 20 193	33 Pennsylvania
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland Washington Hagerstown	1 ☐Yes 2 🏋 No
Maryland Washington Hagerstown Section 2015 Maryland Washington Hagerstown Maryland Washington Mary	ten of What Country?
27 Atlantic Drive	U.S.A.
27 Atlantic Drive 21/42 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 21/42 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 21/42 13. Was Decedent Fiver in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married	4. Race - American Indian,
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The state of the s	nd of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+) Laborer Rible 18. Mother's Name (First, Middle, Maiden S	bon Mfg. Company
18. Mother's Name (First, Middle, Maiden S	·
Sammuel E. Shoemaker 18. Mother's Name (First, Middle, Maiden S Margaret P. Pike	Shoemaker
Elementary/Secondary (0-12) College (1-4or 5+) Laborer Ribt College (1-4or 5+) Laborer Ribt College (1-4or 5+) Laborer Ribt Sammuel E. Shoemaker 19a. Informant's Name/Relationship (Type. Print) Charles E. Sanbower Ir. Son 12307 W. Lawn Lane Hagerstown Mar	
The property of the property o	ryland 21/40 cation - City or Town, State
20a. Method of Disposition Comparison C	erstown Maryland
Charles E. Sanbower, Jr. Son 12307 W. Lawn Lane Hagerstown Mar 2002. Loc 1202. Method of Disposition 3 Removal from State 1202. Name and Address of Facility Douglas A. Field 1331 Eastern Blvd. N. Hagerstown Mar 2002. Loc 1202. Name and Address of Facility Douglas A. Field 1331 Eastern Blvd. N. Hagerstown Mar 2003. Method of Disposition Mark 2004. Mark 2005. Loc 1203. Name and Address of Facility Douglas A. Field 1331 Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Address of Facility Douglas A. Field 1331 Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Address of Facility Douglas A. Field 1331 Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Address of Facility Douglas A. Field 1331 Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Address of Facility Douglas A. Field 1331 Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Address of Facility Douglas A. Field 1331 Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Address of Facility Douglas A. Field 1331 Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Address of Facility Douglas A. Field 1331 Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Address of Facility Douglas A. Field 1331 Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Eastern Blvd. N. Hagerstown Mark 2005. Loc 1203. Name and Eastern Blvd. Name and Eastern Blvd. Name and Eastern Blvd. Name and Eastern Blvd. Name and Eastern Blvd. Name and Eastern Blvd. Name and Eastern Blvd. Name and Eastern Blvd. Name and Eas	ery Funeral Home
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Physician Immediate Cause (Final disease or condition #FDA71/ ©NCEPHALOPATHY	Onset and Death
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
that initiated events resulting in death) Last Due to (or as a consequence of):	
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to Die S IEEEMALE	
23c. If yes, outcome pf pregnancy 1	3d. Date of delivery Month Day Year
23b. Was decedent pregnant in the past 12 months? 1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	se contribute to the cause of death?
E SUBJECTION OF BREACY CANCER 10 Yes 20	No 3 Probably 4 Unknown
	24b. Were autopsy findings available prior to completion of cause of
d) d g N Q VIV LV L C V L C V V V V V V V V V V V V V	death? 1 ☐ Yes 2 ☐ No
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autopsy performed? 1	d Number or Rural Route Number, and manner as stated. place, and due to the cause(s)

			For State Registrar	State of Mary	land / De	partment of F ertificate of	lealth and M <i>Death</i>		en 2 0 0	7 29130
ż	407	1	Decedent's Name (First, Middle, La.	st)				2. Date of Death		3. Time of Death
- 3	Physici	or.	Ronald	G	S	chaffer		August		1:07 A M
3 C (8)	/Medic Examin		4a. Facility Name (If not institution, giv				r Location of Death		4c. County o	
		ie V n	102 Church Stree	t			Springs			omico
	Funeral		5. Social Security Number 6. S	XIM 2DE	yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace (State or Foreign Country)
5	Director		220-28-1275 Usual Residence of Decedent		2 ***			Oct. 31,	,1934	Maryland
	/land		10a. State 10b. County	100	c. City, Town o	r Location				10d. Inside City Limits
	Marie 1	tor	MD Wicomio	20	Marde	la Springs				1X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wi	hat Country?
	23a		102 Church Stree			21837			USA	
	tems	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	 Was Decedent of H If Yes, specify Cubi 	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
36	hours after death with the Maryland turel', or Heme 23a or 28a-f ehow at Examical mind be tryllifed at	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No 1 If Yes, Give Year or Dates: 1	957-	1 ☐ Yes 2 № No	Specify:		Specify:	White
Ş	2 hou		15. Decedent's E	ducation	16a. D	ecedent's Usual Occup	pation	1	6b. Kind of Bus	siness/Industry
21215-0036	hin 7.	Completed	(Specify only highest gra	College (1-4or 5+)	- (C	ive kind of work done e. DO NOT use retire	during most of work d)	ing		
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3	should be filed within 72 hours after death with the Marylan nd Mental Hyglene. s marked other than "naturel", or items 23a or 28a-f ehow umatic event, the Madital Examilar must be untilled at	4	Leslie G. Schaffe 19a. Informant's Name/Relationship (10h h	ailing Address (Street	Mary Be		City of Tours	State Zin Code)
<u>a</u>	d 2 shd th and 7 ts mu treum		Harriett Schaffer							
ē	s 1 and 2 should if Health and Men item 27 is marke other treumatic		20a. Method of Disposition		0b. Place of D	Church Sta sposition (Name of crematory or other plan		Date 2	0c. Location - C	Dity or Town, State
<u> </u>			1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		-	Creek Cemet		-2007 Ma	rdela S	Springs, MD
altimore,	permit. Page Department of Importent: if any injury or ance.		21. Signature of Funeral Service Licer		15000	22. Name and Addre				
ñ	Por in the		Malson Hu	y Elke		705 E Main	St Salis	bury, MD	21804	
100			23a. Part1. Enter the disease, or conshock, or heart failure. List only	olications that caused the one cause on each line.	death. Do not	enter the mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
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1932	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of)					
15		60	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of)					
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-	ing ph		IF FEMALE:							
Вох	leath certifi attending I for use as	ician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	Fetaf death	3 Ectopic pregnance	у		23d. Date Mont	of delivery th Day Year
o.	he de the a	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡ Pregnant at time 9⊡ Unknown	of death	5 ☐ Other (specify) _				
۵.	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	y Ph	Part II. Other significant conditions	contributing to death but no	ot resulting in th	e underlying cause giv	ven in Part I.	23e. Did tob	acco use contril	bute to the cause of death?
g	quires n sign ald be	d by						1 ☐ Yes	s 22 No :	3 ☐ Probably 4 ☐Unknown
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ta.	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Pface of Deat	h (Check only one		
<u>></u>	Attending Physicien: Ir death. ector: After this certification: by the funeral director.	10	1 ☐ Yes 2 50 No	Hospital: 1 ☐ Inpatient	2 EP/Outp		ner: 4 ☐ Nursing Ho	-	nce 6 Othe	
n c	ding P h. After I funera	lon:	27. Manner of D ath Naturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Tin	ry Wo	rk?	28d. Tescribe how	w infury occurre	ed
Division of Vital	Attending or death.	icat	2 Accident investigatio 3 Suicide 6 Could not b	e Jee Blace of frigue	At home farm	M 1	Yes 2 □No	28f Location (Str	eet and Numbe	or or Rural Route Number,
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_	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	O	29a. Certifier Certifying Pl	nysician: To the best of m	y knowledge, o	leath occurred at the ti	me, date and place,	and due to the ca	use(s) and man	nner as stated.
	n 24 t	Medical	(Check only 2 Medical Example)	miner: On the basis of exa and manner stated.	amination and/	or investigation, in my	pinion, death occur	red at the time, da	ite and place, a	nd due to the cause(s)
	To the within To the comp	Σ	29b. Signature and title of cartifier	00	AAN	29c. Licens	se number	29	d. Date signed	(Month, Day, Year)
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	5 11.		30. Name and address of person who				2 6 1	1 1/1	N 2	1977-
183	OLL	10	31. Date filed (Month, play Year) Pri	2007 32. Redistrars	Signature	לון קיימט	00119) 101	U rl	00-
100	Registi		AUG 2 7	2007 Glasson	K	(souls)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 23 Year **Physician** 09: 40AM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and nymber, 4b. City, Town, or Location of Death Examiner Wicomico lisbury Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. 2/17/1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months MXM 2□F Director 83 224-28-8319 Virginia Usual Residence of Decedent a or 28a-f show be notified at 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits 1X Yes 2 □ No Director Virginia | Accomack New Church 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and 2 should be filed within 72 hours after death with teath and Mental Hygiene. 4]67 Lankford Highway

11. Marital Status

1 □ Never Married 2 Married

1 □ Never Married 4 □ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 □ Never Married 4 □ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

12. Was Decedent Ever in U.S. Armed Forces?

12. Was Decedent Ever in U.S. Armed Forces?

4 □ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

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12. Was Decedent Ever in U.S. Armed Forces?

4 □ Divorced

12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 23a selical Examiner must b Completed by Funeral 23415 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White er than "nature the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Govt./NASA Carpenter/Craftsman permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Mamie M. Massey Norman A. Shields 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Petitt Shields (wife) 4167 Lankford Hwy., New Church, VA 23415 20b. Place of Disposition (Name of cemetery, crematory or other place)
Downing's Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/26/07 Oak Hall, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee Thornton Funeral Home Inc. 24183 Chadbourne St. Parksley, VA 23421 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ud **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 Yes 2 No 1 Hospital or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospital: 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide with...

To the Fu...

Completely fill 1 🖍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 29505 08-24-2007

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 2

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR. SALISBURY, M.D. 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 18, SYLVIA SMITH 2007 1:35 Pm Aug K. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9000 Briarcroft Lane Laurel Prince George If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov. 8, 1938 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F 68 Wash.DC Director 215-36-4116 Usual Residence of Decedent death with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Laurel MD Prince Georges 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 9000 Briarcroft Lane 20708 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Pr. Georges Elementary/Secondary (0-12) College (1-4or 5+) Bus Attendant Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Geneva Smith William Tolliver ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin N. Smith (Son) 8164 Fenwick Court, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State MD Nat'l Mem Park 8/25/07 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) re T Funeral Service Utense 22. Name and Address of Facility SNOWDEN FUNERAL HOME 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Priystellan Cerebral Thrombosis Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Adenocarcinoma Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed Breast Cancer Years physician and s the burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? 1∐ Yes 2X No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

24 hours a Hospital To the I within 2

10

Medical

State

29b. Signature and title of certifie

M.D. 321 Prince George St, Laurel, MD 20808 William A. Warren, 32. Restrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

8/20/07

			For State Registrar	State of Marylan		artment of rtificate of				ene 2 0	107	29	133
ò	Physicia	e an	1. Decedent's Name (First, Middle, Last)						ate of Death	Day	Year	3. Time of	M
- 365 - 254 - 254	/Medic	al	Gary Elliott Sco			4b. City, Town,	or Location	Aug of Death	. 26,	2007 4c. County	of Death	5:44	A W
<i>*</i>	Examin	er	Gilchrist Hospice (Towsor		or Boati		1	imor	е	
gg *	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Yea Months Days	r If Under		ate of Birth fonth, Day,			lace (State o	or Foreign
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	land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					1	0d. Inside C	ity Limits
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	s 23a nust t	eral	12017 Open Run Rd.	2. Was Decedent Ever in U	C 12	21042		igin? (Specify V	as or No-	USA 14 Bac	e - Americ	an Indian.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 🖾 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes ※ No			, etc.)		ck, White,	etc.	
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an	Mental Mental arked o	To Be	Charles E. Scott				Jear	n Sargei	nt				
Maryland	2 should l and Men is marker aumatic		19a. Informant's Name/Relationship (Typ	ne. Print)	19b. Maili	ng Address (Stree	et and Numb	er or Rural Rou	ite Number,	City or Town,	State, Zip	Code)	
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Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License		22	2. Name and Add	ress of Facili	Harry I	H. Wit	zke's	Fami.	ly FH	Inc.
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	dical	(Check only 2 Medical Examir one)	sician: To the best of my kniner: On the basis of examinand manner stated.	ation and/or i	nvestigation, in m	y opinion, de	eath occurred at	the time, da	ate and place	, and due t	o the cause	
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			Marlin)		0	> 050	ک	/	Ngust	26	, ,00	/
(8	00		30. Name and address of person who co	mpleted cause of death (Itel	m 23a) (Type 701 N	Print)	SIF	70 N.	SUN	np z	1200	7	
Ĭ	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature #	hand .					/		
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7-06756 shley Sanders	State 1- For State Registrar			al Hygiene	200	7 2913
Physician/ Medical Examine		ASHLEY LYNN SAND		2. Date of Death Month August 31,	Day Year 2007	3. Time of Death 0605 hrs
	4a. Facility Name (if not institution, gi 10 Sunny Court		4b. City, Town, or Location of Thurmont	- 3 - 1 - 4	4c. County of Death Frederick	
Funeral Director	5. Social Security Number 6. S 216-25-4871 1	ex 7. Age (In yrs. last birthd	ay) If Under 1 Year If Under Months Days Hours	Min	(MM/DD/YYYY) 9. Bir Foreig 17, 1986 ^{Co}	
iow any	Usual Residence of Decedent 10a. State 10b. County Maryland Freder	.ck 10c. City, Town or			<u>ia</u>	10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 10 Sunny Court	Thurmo	10f. Zip Code 21788	- 10	g. Citizen of What Coul	ntry?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Marial Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Marrie	Armed Forces? No	3: Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F		White, etc.	ican Indian, Black,
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Baltimore, permit. Pages 1 ar Department of Hee Important: If the injury or other tr	4 Donation 5 Other Special 21. Signature of Funeral Pervice Lice	y:	23 Name and Address of Facility 0BERT E DAILEY 15 EAST MAIN ST		Thurmont, ERAL HOMES,	
Physician /Medical xaminer	failure. List only one cause on Immediate Cause (Final disease	plications that caused the death. Do not each line. Methadone intoxicatio	enter the mode of dying, such as car	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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b. Box 68760, the death certificate be executly the attending physician and check for use as the burial - trappy bysician and physician many action of the physician was the burial - trappy of the physician was the burial - trappy of the physician was the physician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown	1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic Other (Specify)	pregnancy	Month	Day Year
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Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune	3 Suicide 6 X Could not determine determine	ed (Specify) Home	m, street, factory, office building, etc	or Town, S 10 Sunn	state) <mark>v Ct. Thurmont</mark>	
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To T Com	29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed (Me	onth, Day, Year)

31. Date filed (Mo. 2), Year) 2007

OCME

orlevi 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 31, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2007 10.09AM 9 MARY CATHERINE SUTTON AUG 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE ST AGNES HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🗙 F APRIL 24, 1911 PENNSYLVANIA 96 212-22-5929 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ▼ No Director MARYLAND QUEEN ANNE'S STEVENSVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 200 TERRAPIN GROVE, APT 123 21666 UNITED STATES Funeral Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🗓 No Specify. þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SEWING **TEXTILES** 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PAULINE VANCHERI VINCENT BIZZARRI ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8610 LUCERNE ROAD, RANDALLSTOWN, MARYLAND 21133 ROSEMARIE BRILL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State AUGUST 30 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2007 STEVENSVILLE, MARYLAND STEVENSVILLE CEMETERY FELLOWS. HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 21. Signaty 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com-shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) PNEUMONIA 7 DAYS Due to (or as a consequence of): FAILURE FDAYS. ONGESTIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) P Completed Be Medical Certification: To

The law requires that the death certificate be executed use as the burial-transi and igned by the attending physician be detached for use as the buria has Division or Vital spital or Attending Physician; Theoris after death.
Ineral Director; After this certificate
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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

9 □ Unknown	9LIUnknown				
art II. Other significant conditions co	ntributing to death but not res	ulting in the underlying o	cause given in Part I.		use contribute to the cause of death?
				24a. Was an autopsy performed? 1 Yes 2 XN	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ⋈ No
5. Was case referred to medical			26. Place of Dea	h (Check only one)	
examiner? 1 Tyes 2 No	Hospital: 1 npatient 2	ER/Outpatient 3 Do	OA Other: 4 Nursing He	ome 5 Residence	6 □Other (Specify)
7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specif		ry, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, te)
	sician: To the best of my kno				s) and manner as stated.

29c. License number

P1992

2

Hospital e Funeral To the l

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Suvalchala

29d. Date signed (Month, Day, Year)

AUG

26 2007

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SUVARCHALA 900 AUC KOMPELLA (ATON BALTIMORE

State Registrar



MD

			1 - State Registrar		-	Certificate of		Reg	J. No. 2007	29136
	Physici		1. Decedent's Name (First, Middle, La RODNEY LOUIS		JR.		A. A.		23, 2007 Year	3. Time of Death 10:45A M
)	/Medic Examin		4a. Facility Name (If not institution, given 149 JEFFERSON F			4b. City, Town, c	or Location of Death		4c. County of Death	
	Funeral Director		219-98-9727	Sex 7. Age 1 MX M 2 □ F	(In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Y PT. 10,	(ear) 9. Birthr Court 1981 MARY	place (State or Foreign htry) LAND
	ne Maryland 8a-f show ptified at	ector	Usual Residence of Decedent 10a. State 10b. County MD CHARI		10c. City, Town	7				0d. Inside City Limits 1 XYes 2 No
	h with the	al Dire	149 JEFFERSON ROA	AD		10f. Zip Code	20603	_	g. Citizen of What Coul JNITED STAT	-
036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural"; or items 23a or 28a-f show other than "natural"; or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: BLA	etc.
15-0036	n 72 ho " natur edical i	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Decedent's Usual Occup Give kind of work done life. DO NOT use retire	oation during most of working d)	16	6b. Kind of Business/In	dustry
717	ed withi /giene. er than t, the M	Comp	Elementary/Secondary (0-12)	College (1-4or 5+	1	ABORER			CONSTRUCTIO	N
_	0 = 0 %	æ	17. Father's Name (First, Middle, Last RODNEY LOUIS SHORT				18. Mother's Name (Fi		,	
, mary	and 2 shou valth and M 1 27 is mar er traumati		19a. Informant's Name/Relationship (LOUISE PROCTOR/AUI				and Number or Rural Re ROAD, WALD			Code)
saitimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ed once.		20a. Method of Disposition 1 Burlal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Content of the Content	fy)		Disposition (Name of crematory or other plance TER S CH.CE	M. 8/29/2	2007 V	NALDORF, MA	RYLAND
משו	permit Depart Import any in once,		21. Signature of Funeral Styre in LADIA C. THOR	NTOX JOHNSO	N	22. Name and Addre	ess of Facility FUNERAL HOM NGSTON ROAD	E, PA	AN HEAD, MI	20640
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Enter Indertying	Due to (or as a		i):	ng, such as cardiac or re	espiratory arres	st,	Approximate Interval Between Onset and Death
68760,	rificate be executed ig physician and as the burial-transit	ledical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	consequence of	r):				
	w requires that the death certif been signed by the attending should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deliv Month	ery Day Year
ords, r	equires tha en signed l	b	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cause gi	ven in Part I.		acco use contribute to t	v
L Kec	The larate has	Completed						24a. Was an autopsy performe 1 Yes 2	prior to co	opsy findings available mpletion of cause of 2□ No
VItal	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Tyes 2 X No	Hospital: 1 ☐ Inpatien	t 2 ER/Out	patient 3 DOA Oth	26. Place of Death (C ner: 4 ☐ Nursing Home) nce 6 □Other (Speci	fv)
IVISION	or Attending ter death. Jirector: After In by the fune	Certification: T	27. Manner of Death 1 Matural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	e oo plans of injury	Year) In	jury Wo	ry at rk?]Yes 2 □ No	. Describe how	v injury occurred eet and Number or Run	
_	ne Hospital on 24 hours af ne Funeral Dietely filled i	Medical C	29a. Certifier (Check only one) 1	hysician: To the best of miner: On the basis of and manner state	examination and	death occurred at the t /or investigation, in my	ime, date and place, and opinion, death occurred	due to the cau at the time, dat	use(s) and manner as s te and place, and due f	stated. to the cause(s)
	To the I within 2. To the I complet	M	29b. Signature and title of certifier	MMall		29c. Licens D2835		290	d. Date signed <i>(Month,</i> 8/24/07	Day, Year)
9	B1		30. Name and address of person who	D O ROV 17	O3 TA	DIATA MD 2	20646			
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 8	2007 32. Sigistral	's Signature	Sporte				

DHMH 17 Rev 1/2001

		•	1 - For State Registrar	State of Ma		artment of F	lealth and Me Death		ene 2007	29137
	Physici		1. Decedent's Name (First, Middle	Simpson			2	Date of Death Month	Day Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution			4b. City, Town, o	r Location of Death		4c. County of Death	1.700
			23 Foxwood	Dr		EIKT	00		Ceci	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday 58 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Young . 29 .	(ear) 9. Birti Co. 1948 Penr	nplace (State or Foreign untry)
	Director		209-38-0384 Usual Residence of Decedent					ug. 29,	1940 Felli	•
	ehow	_	10a. State 10b. County		10c. City, Town or L	ocation.				10d. Inside City Limits 1 ☐ Yes 270 No
	28e-f	Director	Maryland Cec:	<u>i1</u>	E1kton	10f. Zip Code		100	g. Citizen of What Co	
	3a or		23 Foxwood La	ne		21921			nited Stat	•
	Items 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13		dispanic Origin? (Speci an, Mexican, Puerto Ri		14. Race - Ame Black, White	rican Indian,
36	72 hours after death with the Maryland natural', or Items 23s or 286-1 ehow deal Establish and be notified at	by Fu	1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 💢	No	1 ☐ Yes 2 📉 No	Specify:		Specify: W	nite
21215-0036	2 hour	ed b	15. Deceden	Year or Dates:	16a. Dec	edent's Usual Occup	pation		Sb. Kind of Business/	Industry
215	S _ 3	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4or 5	life.	e kind of work done DO NOT use retired	during most of working d)			
2	filed with Hygiene ther the		12	(ant)	Но	memaker	18. Mother's Name (First Middle Ma	Own Home	
and	a la b	o Be	17. Father's Name (First, Middle, James Simpson	Last/			Elizabet			
Maryland	d 2 should the and Men 17 is marke traumatic	To	19a. Informant's Name/Relations	hip (Type, Print)	19b. Mai	ling Address (Street	and Number or Rural I			Tip Code)
	1 and 2 Heelth a tem 27 is		Robert Patrick	Lamb / Son			ne, Elkton			
Baltimore,	t H of H		20a. Method of Disposition 1 □ Burial 2 X Cremation	3 Removal from State	,	ematory or other pla	Augus	t	Oc. Location - City or	
I I	permit. Pages Department of Important: If I any Injury or one		4 Donation 5 Other (S	Decity)		e Cremato	239 2		ewark, Del	
Ba	Department in position		> (blasses				01		neral Home h East, Ma	ryland 2190
	Physician		shock, or heart failure. List Immediate Cause (Final	complications that caused only one cause on each li	the death. Do not en	nter the mode of dying		respiratory arres		Approximate Interval Between Onset and Death Un Known
1	/Medical		disease or condition resulting in death)		a consequence of):		110000			En coal
	Examiner	L	Sequentially list conditions,	D	a consequence of):	511				79829
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	BETES					
Ć.	ite be executed ysicien and ne burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
3760,	# × 9	icai		d						
x 68	leath certificat ettending phy ifor use as th	/Med	IF FEMALE:	23c. If yes, outcome	of prechancy				23d. Date of del	ivon
Box	0 0 0	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No		2 Fetal death 3	☐Ectopic pregnanc ☐ Other (specify) _	y		Month	Day Year
P.0	at the de	Phys	9 Unknown		ust not appointing in the	underhing souss on	on in Bart I	23e Did toba	acco use contribute to	the cause of death?
	The law requires that the ste has been signed by the bage 2 should be detache	þ	Part II. Other significant condition	ons contributing to death b	iut not resulting in the	underlying cause giv	ren in Fait I.		2 □ No 3 □ Pr	
Records,	w require been si should t	Completed						24a. Was an	24b. Were au	itopsy findings available
Re	: The law cete hes page 2:	omp						autopsy perform	prior to death? No 1 ☐ Yes	completion of cause of
Vital		BeC	25. Was case referred to medica examiner?				26. Place of Death			
of <	G S	2	1 ∑ Yes 2□No		ent 2 ER/Outpatio	BRI 3L DOA	1er: 4 ☐ Nursing Hom		nce 6 Other (Spe	cify)
uo Ou	ding Ph h. After th funeral	tion:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi		iry 28b. Time Injury	Wo	rk?]Yes 2 □No	d. Describe nov	v injury occurred	
Division	or Attendente death Director: in by the	ifica	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of In	jury - At home, farm, s	street, factory, office	28	If Location (Stre	eet and Number or Ri	ural Route Number,
á	s efte al Dir ed in b	Certification:	4 Homicide	building, et	c. (Specify)			Ony or rown,	Jiaio/	
	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certify (Check only 2 Medical	ng Physicien: To the best Examiner: On the basis of and manner st	f examination and/or	ath occurred at the ti investigation, in my o	me, date and place, ar opinion, death occurred	nd due to the cau d at the time, dat	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To th Within To th comp	Me	29b. Signature and tille of certific	d		29c. Licens	b.	29	d. Date signed (Mont	_
) Cha	1		756	& II	2010	8/23/	
)		30. Name and address of person	SPREET	death (Item 23a) (Type	A/CNN	M)	101MM		
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 8 2	32. Registr	rar's Signature	de				

			for State Registrar		St	tate of M	arylan	d / Depa <i>Cei</i>	ırtment <i>tificate</i>	t of He e of D	ealth and <i>Death</i>	Mental Hy	giene	007	291	38
	Dharatat		1. Decedent's Name	(First, Middl	le, Last)							2. Date of De		Yea	3. Time o	f Death
	Physici /Medic		Richard Carl									Augu	st 17, 2	007	08:15 PN	M
4	Examin	er	4a. Facility Name (If		n, give stree	t and number,)		4b. City,		Location of Dea	ath		County of De	eath	
	Funeral	-	1 Dogwood (5. Social Security No		6. Sex,	7. A	ge (In yrs.	last birthday)	If Under	1 Year	ostburg If Under 24 Hr		rth	9. E	Birthplace (State	or Foreign
и	Director		230-36-0059		1 X M	2□F	73	Yrs.	Months	Days	Hours Mir	February 0	6, 1933	Vir	Country) ginia	
	pug *		Usual Residence of 10a, State	Decedent 10b. County	,		10c Cit	y, Town or Lo	cation				-		10d. Inside C	ity Limits
	Maryli f sho	ō	Maryland	Alleg			Frost		041011						_	2 □ No
	r 28a-	irect	10e. Street and Num	-	wood C	irola	1105	- Louis	10f. Zip	Code			10g. Citiz	en of What	Country?	
	th with	al D		I Dog					2153	2-			U.S.A.			
	tems	Funeral Director	11. Marital Status	i	12. V	Vas Decedent Amed Forces Yes 2	Ever in U.	.S. 13. \	Vas Deced Yes, spec	ent of His	spanic Origin? (n, Mexican, Pue	Specify Yes or No into Rican, etc.)	p- 1	4. Race - Ar Black, W	mencan Indian, hite, etc.	
36	rs afte	by Fi	1 Never Marrie 3 Widowed	•	. '	☐Yes 2 X f Yes, Give ∕ear or Dates:	No		☐ Yes 2	No	Specify:			Specify. Wh	iita	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show deat Erander must be molified at	ted		15. Deceder	nt's Education	n		16a. Deced	lent's Usua	l Occupa	tion	- di/a		nd of Busine		
218	within 7 ene. than "n	Completed	Elementary/Secon	ify only highe ndary (0-12)		npietea) College (1-4or	5+)			e retired)	uring most of w	orking				
121	filed w Hygien ther th		12 17. Father's Name ((Circl Middle	7			professo	or 	· · · · · · · · · · · · · · · · · · ·	10. Mathada Ni	ame (First, Middle		Universit	y	
Maryland	d be feat all be ted of	o Be	Harry Holla		·						Camilla D		, maideir i	ourname)		
ary	should nd Men marke	2	19a. Informant's Na		•	Print)	-	19b. Mailir	g Address			Rural Route Numb	er, City or	Town, State	a, Zip Code)	
	and 2 salth a n 27 is		Ethel Jane S	Sloop		wife		1 Dogw	ood Cir	cle		Frostburg	M	aryland	21532-	
ore,	es 1 a of He f Item r oth		20a. Method of Disp	osition	3 Demo	val from State	1	lace of Dispo emetery, cren	sition /Nam	e of)	Date	20c. Loc	cation - City	or Town, State	
Ë	ment ment ient: I		` 4 Donation	5 Other (S	Specify)	variioiii State	Frost	tburg Me	morial I	Park	Aug	ıst 21, 2007	Frostb	urg N	faryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, If a M-51c-1 Eracin at most be notified at once.		21. Signature of Fur	neral Service	Licensee	4)ur	est		. Name and Jurs t Fu			Frost Ave.,	Frostbu	ırg, MD	21532	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the shock, or hear shock, or hear shock and shoc	rt failure. List	a	Due to (or as	ine. 257 s a consequ	uence of):		,		CINO			Approxima Interval Be Onset and	tween
(09289	The faw requires that the death centificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	edical	resulting in death) L	.ast		Due to (or as	a consequ	uence of);								
P.O. Box	that the death certifined by the attending of	Physiclan/M	23b. Was decedent in the past 12 in 12 Yes 2 9 Unknown	months?	1	f yes, outcome Live birth Pregnant a Unknown	2 Fetal	death 3	Ectopic pre Other (spe				2	3d. Date of o	,	Year
	w requires tha been signed should be del	by	Part II. Other signifi	icant conditi	ons contribu	iting to death t	out not resi	ulting in the ur	nderlying ca	ause giver	n in Part I.				to the cause of Probably 4	
al Records,		Completed										24a. Was auto perfe 1 \(\text{Yes}		24b. Were prior to death	autopsy findings to completion of c ? es 2 \(\text{No} \)	available cause of
of Vital	Physicien: this certific ral director.	o Be	25. Was case referr examiner? 1 🗆 Yes 2		Hospi	tal:	0.00	ER/Outpatien	3 DO	Othor		eath (Check only		C1045 /-		
	> 00 0	n: To	27. Manner of Death	1		Ba. Date of Inju	шгу	28b. Time of		Bc. Injury Work	4 Nursing	Home 5 Pes			ресту)	
ion	Attending F ir death. ector: After by the funer	atlo	1y Natural 2 ☐ Accident		gation	(Month, Da	ay rear)	Injury	м		es 2 🗆 No					
Division	al or Atter after de Directo d in by the	Certification:	3 🗌 Suicide 4 🔲 Homicide	6 Could detern		Be. Place of In building, e	jury - At ho tc. (Specify	ome, farm, str	eet, factory	, office		28f. Location (City or To	Street and wn, State)	l Number or	Rural Route Nun	nber,
	To the Hospital or Attending Phwitin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)	1 Certifyii 2 Medical	Examiner:	n: To the best On the basis of and manner \$1	of examina	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	e, date and place inion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner place, and d	as stated. lue to the cause(s)
	To the within To the comp	Me	29b. Signature and	sitte of certifie	or /	///		11		License					onth. Day, Year)	
•	10		16	non	91	hr	All	mo		0	3513	5		8/	20/03	7
UT-	Mes		Inpu	745.	EI	eted caus	///	10	Print)	912	Sphon	D- C	in.	berla	not M	U
B	Sta Registr		31. Date filed (Mont	UG 2	2007	32. Fegist	ar's Signa	ture								

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		Cei	rtificate of L	Death	F	teg. No.	907	29	130
N. A. S. S. S. S. S. S. S. S. S. S. S. S. S.	Physicia		1. Decedent's Name (First, Middle, Las Mary	Jeanette		Stitche	r	2. Date of Dea Month August	Day	Year 007	3. Time of E	Death A M
	/Medic Examin	143	4a. Facility Name (If not institution, give			Cumi	Location of Death berland		4c. Count	ty of Death Allega		
3 - A	Funeral Director		213-14-0434	ex 7. Age (<i>In yrs</i> .	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10/13/	, Yea <i>r</i>)	9. Birthp Coun Mary		Foreign
	h the Maryland or 28a-f show e notified at	Director	Usual Residence of Decedent		ty, Town or Lo	umberland	1		10g. Citizen ol	f What Coun	0d. Inside City 1 ☐ Yes	
336	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11313 Sunny L 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	ane 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give X Year or Dates:			21502 lispanic Origin? (Span, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Ra Bl			
21215-0036	within 72 hor ene. than "naturi he Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired Homemaker	eation during most of work d)	ing	16b. Kind of	Business/Ind Home	dustry	
Maryland 2	2 should be filed vand Mental Hygie is marked other is raumatic event, th	To Be Co	17. Father's Name (<i>First, Middle, Last</i> Daniel	Theodore		cay	18. Mother's Name Cather		Maiden Surna	ame)	emp	
	t and 2 shou Health and N tem 27 is mai		19a. Informant's Name/Relationship (Gary W. Zoppo / S	Son	4915	5 Wright	Avenue, E			21205	5	
Baltimore,	permit. Pages 1 al Department of Hee Important: If item any Injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification 21. Signature of Full eral Service Lice	Removal from State (5)	<i>cemetery, cre</i> mberlai	2. Name and Addre	ory 08/2 ss of Facility Ac	1/2007 ams Fam	Cumbe	rland, neral	, MD	P.A.
Bottoffee	Physician /Medical	10 11	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	iplications that caused the dear one cause on each line. a. Arteriscl Due to (or as a conse	erstic	ter the mode of dyir	ng, such as cardiac	<u> </u>			Approximate Interval Bety Onset and D	veen Jeath
68760,	icate be executed physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	b								
.O. Box 68	ath certif ttending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 ☐Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 l	□Ectopic pregnanc	у			Date of delive		'ear
Δ.	fuires that the de n signed by the a lid be detached f	by	Part II. Other significant conditions	contributing to death but not re	sulting in the u	underlying cause giv	ven in Part I.		obacco use co Yes 2 □ No			eath? Jnknown
al Records,	≥ Q 2	Completed						1□ Yes	psy prmed? 2 1 No	b. Were auto prior to co death? 1 □ Yes	opsy findings a empletion of ca 2 \square No	available ause of
Vital	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital: 4 Dispetient 25		. all par Ott	26. Place of Dea					_
o	Ilng After fune	ation: To	1 \overline{\overline{N}} Yes 2 \subseteq No 27. Manner of Death 1 \overline{\overline{N}} Natural 5 \subseteq Pending investigation 2 \subseteq Accident	28a. Date of Injury (Month, Day Year)	28b. Time (Injury	of 28c. Inju	4 Li Nursing n	ome 5 X Resi 28d. Describe	how injury occ	curred		
Division	i Di te	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Spec	cify)		y:	28f. Location (City or To	wn, State)			ber,
	thin 24 hours at the Funeral outpetely filled	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	hysician: To the best of my kruminer: On the basis of examinand manner stated.	nation and/or i	investigation, in my	opinion, death occu	rred at the time	, date and place	ce, and due	to the cause(s	6)
	2		> Dout	o completed cause of death (Ite	em 23a) (Type		9157		_		0, 200	7
	nes	ate			West		reet, Cumb	perland,	, MD 2	21502		
	Regist		AUG 2 1 2007	Dear H		Les de la company de la compan						

FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectopic pr			23d. Date of delivery Month Day Year
rt II. Other significant conditions	•	sulting in the underlying c	ause given in Part I.		o use contribute to the cause of death? 2♥No 3□ Probably 4□Unknown
				24a. Was an autopsy performed' 1∐ Yes 2☑	
. Was case referred to medical			26. Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2]ER/Outpatient 3 □ DC	Other: 4 Nursing H	lome 5 Besidence	6 ☐Other (Specify)
. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, factory	r, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
Pa. Certifier (Check only one) 1 Certifying P 2 Medical Exa	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place, in my opinion, death occu	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
b. Signature and title of certifier	/	290	: License number	29d. I	Date signed (Month, Day, Year)
> Virgen			D52931	1	AUG. 13,2007
. Name and add ss person who	completed cause of death (Ite	m 23a) (Type, Print)			
VIRGINIA MAGBOJO	OS, M.D 912 S	SETON DRIVE	CUMBERLAND	, MD 21502	2
Date filed (Month, Day, Year) AUG 2 0	2007 32. Redistrar's Sign	ature			
		*			
		ORIGINAL			

2007

ALLEGANY

14. Race - American Indian,

WHITE

21502

Approximate Interval Between Onset and Death

Black, White, etc.

Specify:

12:37 P M

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 No

PENNŚYLVANIA

page 2 s To the Hospital or Attending Physician: funeral director, this After fter death filled in by within 24 hours a completely

Be

Certification: To

Medical

25. Was case referred to medical examiner?

29b. Signature and title of certifier

27. Manner of Death

29a. Certifier

31. Date filed (Month

Registrar

nds

State

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State	of Mary	land / D	onartmont	of Ho	alth and l	Montal	Hygione	

			State of Maryland / Department of Health and N 1- State Registrar Certificate of Death			27 00111
	g.		1. Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death
	Physici /Medic	-	Gertrude E. Sutton	Month 08	3/24/2007	10:35 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Magnolia Center Lanham		4c. County of I	Death ce George's
- 93 65	Funeral Director		5. Social Security Number 578-03-7010 6. Sex 1	8. Date of Birth Month, Day 02/28/	'1 ^Y 68GO	Birthplace (State or Foreign Country) ashington DC
	yland now at		Usual Residence of Decedent 10a. State MD Prince George's 10c. City, Town or Location Lanham			10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code	1	10g. Citizen of Wha	1
	leath w ns 23a must b	Funeral	8200 Good Luck Rd 11. Marrital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - /	American Indian,
980	urs after d al', or iten Examiner	by	Armed Forces? If Yes, specify Cuban, Mexican, Puèric 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	Rićan, etc.)		White, etc. White
Maryland 21215-0036	ithin 72 ho ne. nan "natur Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Busin	ess/Industry
d 21	filed w Hygier ther th		9 Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Nam	e (First, Middle,	Food Maiden Surname)	
/lan	wuld be Mental arked c	To Be		Thompson		
	and 2 sho ealth and 1 27 Is ma er traums		19a. Informant's Name/Relationship (Type. Print) Doris Grempler/daughter-in-law 19b. Mailing Address (Street and Number or Ru., Lank			ate, Zip Code)
nore	ages 1 ant of He it: If Item or oth		1 M Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	Date 2.42007	20c. Location - Cit	
Baltimore,	permit. P Departme Importani any Injury once.	Ì		rt Linco	Brentwood	al Home
			Section 1 Section 1 Section 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition a. Chronic Obstructive Lung Disease resulting in death)	e		Onset and Death year
	Examiner		Due to (or as a consequence of):			
	ted .	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			
30,	cate be executed physician and the burial-transit	I Examine	that initiated events resulting in death) Last Due to (or as a consequence of):			
68760,	ificate b g physic as the b	edical	d			
.O. Box	that the death certificed by the attending podetached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date o Month	. ,
Δ.	as and as	ρλ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ite to the cause of death? ☐ Probably 4 ☐Unknown
I Records,		Completed		24a. Was a autop: perfor	sy prio med? dea	re autopsy findings available or to completion of cause of th? Yes 2 □ No
Vita	Physician; The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Type 257 No Hospital: 1 Type 257 No Other: 277 DOA Other: 277 No Oth			
0		n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ence 6 Other ((Specify)
Division or Vital	or Attending after death. Director: Afte in by the fune	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office	28f. Location (S	treet and Number	or Rural Route Number,
<u>></u>	Ital or A rs after ral Dire	Certif	4 ☐ Homicide building, etc. (Specify)	City or Tow	n, State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	To the within 2 To the complete	Me	29b. Signature and title of certifier 29c. License number D. 01852		29d. Date signed (A	
0	(2)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			728,2007
1/2	- (2)		Paul A. Devore, MD, 4203 Queensbury Rd., Hyattsville	, MD 207	81	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 8 2007 Security D. April			

		1 - State Registrar			State o					Death			F	Reg. No.	20	07	29	14:
	ian cal	1. Decedent's Nam MUHAMAD	e (First, Middle	e, Last)	S	ALEH	_						te of Dea onth 9 W.Q.T	4 27	7 2	Year 2007		of Death
	ner	4a. Facility Name (y, Town, c VHAM	or Location	of Death		,		County o		RGE	
		5. Social Security N 568-24-2		6. Sex	M 2□F	7. Age (In yrs	. last birthda Yrs.	/) If Und Months	er 1 Year s Days	If Under Hours	Min.] (Me	te of Birth onth, Day	n, Year) 192		Coun	lace (Stai	e or Foreign
		Usual Residence o	f Decedent 10b. County			10c. C	ity, Town or	ocation								1	0d. Inside	City Limits
	ctor	MD	PRINCE	GEO	RGE	ВО	WIE										1 ₹□ Y	es 2∐No
	Dire	10e. Street and Nu 12921 GL		יידים בי א	т стр	CIE			Zip Code					10g. Citiz	zen of Wh		itry?	
	by Funeral Director	11. Marital Status 1 Never Mar	ried 2□ Marr	12		edent Ever in rces? 2 X No	U.S. 18	. Was Dec	cedent of F	Hispanic Or ban, Mexica Specify:	n, Puerto	ecify Ye Rican,	es or No- etc.)		14. Race	- Americ , White,		
	eted		15. Decedent	t's Educat st grade c	tion		I (Gi	edent's Us	vork done	durina mos	st of work	ing		16b. Kir	nd of Bus	siness/Inc	dustry	
	Completed	Elementary/Sec	ondary (0-12)		College (1-4or 5+)	life	<i>DO NOT</i> NTREE	use retire	ed)		Ü		P	RIVA	TE		
9	Be C	17. Father's Name	•							18. Moth				Maiden	Surname	;)		_
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l		19a. Informant's N			,		i	•		t and Numb							,	
l		20a. Method of Dis	position				Place of Dis	osition (N	lame of			Date	JE D				wn, State	
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I		21. Signature of F	uneral Service	Licensee	1	10		22. Name	and Addre	ess of Facili	-	JEN	CINS	FUN			E	
Į			1	* 1	1 0		17	474 I	ANDO	VER R	D LA	NDOY	JER.	MD :	2078	5		
		Immediate Cause	art failure. List (Final on	complica only one	cause on e	caused the de each line.	ath. Do not e	nter the m	ode of dyi						2078.	5	Approxir Interval Onset a	nate Between nd Death
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State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 () 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 ear **Physician** August 21, Irini P. Sophocles 1:30 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis 15 King Court If Under 1 Year If Under 24 Hrs. 3. Date of Birth (Month, Day, Year) 9/29/1942 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2X F Months Days Hours Cyprus 214-50-8092 64 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Annapolis Maryland | 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15 King Court 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If then 27 is marked other then." any injury or other traumous. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specity: White Specity: 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specity only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Beauty Shop Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Ioani Eleni Kakoyianni ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Sophocles/ Husband 15 King Court, Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specity) Demetrios Cem. 08/23/2007 Annapolis, Maryland 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home T' 2973 Solomons Island Rd., Edgewater, MD 21037 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 110 Cancer Immediate Cause (Final **Physician** reams disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day 4□Pregnant at time of death 5 ☐ Other (specity) by the 9□Unknown þ has been signed I e 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ mallanam MALLOWIG 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA P this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Natural 2 Accident 5 Pending investigation M 1 ☐ Yes 2 ☐ No neral Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and little of certifier 29c. Ligense number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 1/2001

Registrar

		•	For State Registrar	State of Ma		artment of F ertificate of			iene •g. No. 200	7 29144
	P- 1/2		Decedent's Name (First, Middle, Last)		·			2. Date of Deal		3. Time of Death
Н	Physicia /Medic		Bourdon F. Scribn	er					18, 2007	6:35 P ^M
	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, o	r Location of Dea	ath	4c. County of De	
			Anne Arundel Medica			Annapo1			Anne Ar	
	Funeral		5. Social Security Number 6. Sex	M 2CTE	(In yrs. last birthda) Yrs.	Months Days	Hours Min		Year) (irthplace (State or Foreign Country) aryland
	Director		578-58-8153 Usual Residence of Decedent		11			4/13/1	910 116	ii y i and
	yland		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Mar e-f el	ctor	Maryland Anne Ary	ınde1	Anna	polis				1 Yes 2 XNo
	or 28	Olre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What 0	Country?
	ath w	- Fa	9109 River Crescent		: 110		21401	/O	USA	acces Indian
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic avent, the Medical Exami	by Funeral Director	1 Never Married 2 Married	 Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 	ver in U.S. 13	If Yes, specify Cub:	dispanic Origin? (an, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wh Specify: W	ite, etc.
8	hours ural',	q p	3 Widowed 4 Divorced	Year or Dates:	16a Doo	edent's Usual Occup	ation		16b. Kind of Busines	
5	n 72 n "nai	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Giv	e kind of work done DO NOT use retire	during most of w	orking	Tob. Kind of Busines	amoustry
712	with iene. r ther	mo	Elementary/Secondary (0-12)	College (1-4or 5+ 5+		nemist			Federal G	overnment
ğ	e filec il Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, i	Maiden Sumame)	
<u>a</u>	uid by Menta Vienta Irked	To E	Bourdon W. Scribne	r			Vero	nica McGla	annan	
Baltimore, Maryland 21215-0036	2 should be filed within 7 and Mental Hygiene. ' is marked other than "raumatic avent, I'le Med		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mai	ling Address (Street	and Number or I	Rural Route Number	r, City or Town, State	Zip Code)
<u>√</u>	and lealth m 27		Sally F. Scribner/	Wife	123 F	eppercorn	P1., E	dgewater,	MD 21037 20c. Location - City of	vr Tourn State
0	Pages 1 nent of H ont: if ite ary or oti		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	moval from State	cemetery, cr	ematory or other pla			1	
Ē	it. Pa ritmen ritent: njury		4 □ Donation 5 □ Other (Specify) 21. Signature of fill fine all Service License	•		rematory		1	Edgewater Kalas Fune	
Ba	permit. Pages 1 and 2 Depertment of Health a Importent: If Item 27 la any Injury or othar tras		> / / / / /		2	.973 Solom	ons Isla	and Rd. Ed	dgewater,	MD 21037 Approximate
	Physician /Medical Examiner	_	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a		-ular				Interval Between Onset and Death
8760,	cate be executed obysicien and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.		consequence of):					
.O. Box 6	The law requires that the death certificate be executed at has been signed by the attending physicien and bage 2 should be detached for use as the burral-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown	ic. If yes, outcome or 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	□Ectopic pregnanc	y		23d. Date of d Month	elivery Day Year
rds, P	quires that n signed build be deta	þ	Part II. Other significant conditions conf	ributing to death but	not resulting in the	underlying cause giv	ren in Part I.			to the cause of death? Probably 4 Munknown
Division of Vital Records,	The law re ate has bee bage 2 sho	Completed						24a. Was a autops perform	med2 death'	autopsy findings available o completion of cause of
<u>ta</u>	sentifica ctor,	Bec	25. Was case referred to medical examiner?					eath (Check only or	10)	
>	hysic this ca	၉	1 □ Yes 2 No	ospital: 1 Inpatien		ait SLI DOA			ence 6 Other (Sp	pecify)
ב	ling F	on:	27. Manner of Death 1	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wor	yat rk? Yes 2 □No	280. Describe no	ow injury occurred	
Visio	Attencer death	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	y - At home, farm, s		163 2 2 110	28f. Location (Sincity or Town	treet and Number or on State)	Rural Route Number,
٥	ospitel or A hours efter unerel Diracily filled in by									
	I 4 IT O	edical	29a. Certifier (Check only one) Certifying Physical Examin	ar: On the best of ar: On the basis of e and manner state	my knowledge, dea examination and/or ed.	nvestigation, in my	me, date and pla opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	20 000	nn	29c. Licens	0295	7/	9d. Date signed (Mo	ngh, Day, Year)
•			I way of	7	1/	V U	0-17	/ /	00/11/	
1	SM		30. Name and address of person who cor	npieted cause of dea	atn (Item 23a) (Type	etense	Hwy	Crofi	ton me	121114
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 2 20	32. A distrar	's Signature	Seeds .	-/ **/			as stated. use to the cause(s) nth, Day, Year) 2007
	licgisti	2	שמ א א מ מסת	The same of the sa	- N. J					

07-06593

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 29145 Richard Allen Schwier Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 25, 2007 0850 hrs Richard Allen Schwier Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring 14326 Stilton Circle 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of ton, Washington, If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min Davs Months 39 Director 220-96-0490 Country) DC 1 X M 1967 11, 2 Nov. Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Yes 2 X No or 28a-f show Silver Spring 23a or 28a-f shor Montgomery Maryland Director 10g, Citizen of What Country 10f. Zip Code 10e Street and Number USA 20906 12607 English Orchard Court 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status 12. Was Decedent Ever in U.S. items 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 x No Yes Specify: White Yes 2 X No specify: If Yes, Give Year Pages 1 and 2 should be filed within 72 hours after Divorced Widowed other than "natural", the Medical Examiner ģ 16h, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Electrical Electrician of Health and Mental Hygiene 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Aileen Margaret Paugh William Alvin Schwier t: If item 27 is marked other traumatic event. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, informant's Name/Relationship (Type, Print) MD 20906 12607 English Orchard Court, Silver Spring, Baltimore, MD Tatiana Baker/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Sept. 1, 20a. Method of Disposition crematory or other place) Burial 2 **Cremation 3 Removal from State Alexandria, Virginia 2007 Crematory Metropolitan Donation 5 Other Specify: 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. gn ture of Funeral Service Spring MD Approximate Interva 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MD 20901 **Physician** Between Onset and failure. List only one cause o Madica Death Cocaine intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and for use as the burial - trans Physician/Medical #27,28d,per me, g939 /,28a-f, perME,g871,9/13/ X UNPENDED certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Hospital or Attending Physician: The law requires that the death of 24 hours after death.

Fameral Directors. After this certificate has been signed by the atterstely filled in by the Runeral director, page 2 should be deached for us 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ģ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? ✓ Yes 2 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 No 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred subject took drugs 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Certification: Natural 1 Yes 2 X No Pending Fnd 8/25/2007 Fnd 8:30 am 2 X Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Found face down in neighborhood Suicide or Town, State) 14326 Stilton Cir. Silver Spring, M Homicide vard Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

2007 MARILAR

Assistant Medical Examiner

Dincerti, mis

30. Name and address of person who completed cause of death (Item 23a)

OCME

Donna m

Donna M. Vincenti, MD 31. Date filed (Martin Pay Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 26, 2007

		1 - State of Maryland State of Maryland		artment of Hertificate of L		R	eg. No 2 0	07	29146			
Physici	an	Decedent's Name (First, Middle, Last) SHARON AILEEN THORNTON				2. Date of Deat AUG • 28	- 5007	Year	3. Time of Death 9:14A M			
/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat		4c. County		7.122			
ZAUIIII		CIVISTA MEDICAL CENTER			A PLATA		CHAR					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las 1 ☐ M ★★ 52	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day) 9 – 7 – 19	Year) 54	9. Birthp Cour WAS	place (State or Foreign htry) H., DC			
land		Usual Residence of Decedent 10a. State 10b. County 10c. City, 1	Town or Lo	cation				1	10d. Inside City Limits			
Mary a-f she	tor	MD. CHARLES		WALDOF	RF				1 □Yes 2MNo			
ith the or 28;	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of		ntry?			
eath w is 23a nust f		4275 MARION LANE 11 Marital Status 12. Was Decedent Ever in U.S.	13 \	206 Was Decedent of His		inecify Yes or No-	U.S. A	e · Americ	can Indian,			
-UU36 hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	'	f Yes, specify Cubal	Specify:	to Rican, etc.)	Blac	ok, White, v: WH	etc.			
215-0036 thin 72 hours after te. an "naturai", or Medical Exam		No. 15 and the control of the contro		dent's Usual Occupa kind of work done d		rking	16b. Kind of B	usiness/In	dustry			
	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired,)	ining	OLINI I	70MT				
Ind 21 be filed w Ital Hygier d other ti event, th		12th 17. Father's Name (<i>First, Middle, Last</i>)	j	HOMEMAKE		me (First, Middle, I	OWN I Maiden Surnar					
⊆ ∞ = 0 ≥	To Be	THOMAS MICHAEL MORGAN			NANCY	JOYCE D	AVIS					
ore, Maryland 21 ss 1 and 2 should be filed w of Health and Mental Hygier item 27 is marked other th				ng Address (Street a								
- C - N -	4.5	DONALD E. THORNTON-SPOUS 20a. Method of Disposition 20b. Place		/5 MARIC	ON LN.		, MD . 2					
		1 Naurial 2 Cremation 3 Removal from State	netery, crer	natory or other place	i i			,	,			
Baltimore, permit. Pages 1 au Department of Hea Important: if item any Injury or othe		21. Signature of Funeral Service Licensee M00479) 22 R	2. Name and Addres	s of Facility	SERVIC		•				
A SECUL	LA PLATA MD 20646 23a. Part1. Enter the disease, or complications to fail aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Physician		Immediate Cause (Final disease or condition	he						Interval Between Onset and Death			
/Medical Examiner		resulting in death) Due to (or as * fonseque	nce of):		fai							
	ē	Sequentially list conditions, b. Du lo (or as a conseque)	dem									
No nd ransit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(
cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a conseque	nce of):									
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Box 6 leath certification attending part of the second sec	In/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal d		∃Ectopic pregnancy				ate of delive	,			
I Records, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 1c months? 1 □ Yes 2 ■ No 4 □ Pregnant at time of dea 9 □ Unknown 9 □ Unknown		Other (specify)			M	onth	Day Year			
Cords, P.O. w requires that the di been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulti	ng in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to t	the cause of death?			
Records, he law requires the has been signedge 2 should be d	d by					1 □ Y	es 2 No	3 🗌 Prof	bably 4 ☐Unknown			
Reco le law rel has bee	Completed					24a. Was a		Were auto	opsy findings available ompletion of cause of			
or Vital Re Physician: The Is r this certificate har ral director, page 2	Com					, perfor	med? 2 ☐ No	death? 12 Yes	2 No			
Vital sician: T certificat rector, pa	Be	25. Was case referred to medical examiner? Hospital:		ot acinos Othe	er.	ath (Check only or						
OF Phys er this eral dii	T. To	27. Manner of Death 28a. Date of Injury 2	8b. Time o	II 3 DOA	4 Li Nursing I	Home 5 ☐ Resident Re			<u>fy)</u>			
ion c anding P ath. r: After i	atior	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		Yes 2 □ No							
Division or attending Physafter death. Director: After this d in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At hom building, etc. (Specify)	e, farm, str	reet, factory, office		28f. Location (S City or Tow		per or Run	al Route Number,			
Division or Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, to	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowl physician (Check only one) Medical Examiner: On the basis of examination and manner stated										
ro the vithin 2 omple	Med	29b. Signature and title of certifier		29c. License	e number	2	29d. Date signe	ed (Month,	Day, Year)			
F>F0		refelie M. Tagan	in	Dog	350 88	3	Aug	28	2007			
10		(Check only one) Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier M. Tuffdur 30. Name and address of person who completed cause of death (Item 2) 11655 w. Ne Sp 31. Date filed (Month, Day, Year) SEP 11 2007	3a) (Type,	Print)	. \//	411111	1 Tao	nor	,			
10	oto	31. Date filed (Month, Day, Year) Registrar's Signatu	re	leta M	D YH	7/4 1	. , , ,					
St Regist	ate rar	SEP 1 1 2007 Beaut &	600	West of								

SH-15

Registrar

31. Date tiled (Month, Day, Jear)

SEP 05

251

who completed cause of death (them 23a) (Type Print)

BASY ANTIBTAH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 5:58a M 2007 Alice Estele Thompson 24 August 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Charles Genesis Elder Care Waldorf 8. Date of Birth (Month, Day, Year) July 14, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Washington D.C Days 1 □ M 2 🛛 F 98 Yrs. 1909 577-0**1-**5461 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 □ No Charles Indian Head Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20640 1 Glymont Road 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 21 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Frost Charles A. Ricks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Glymont Road, Indian Head, Maryland 20640 Donald Wilson Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug . 20a. Method of Disposition

11 Burial 2 □ Cremation 3 □ Removal from State 27,2007 20c. Location - City or Town, State Falls Church, Virginia National Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funera M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part1. Enter the di lease, or complications that edused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart foure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F) al disease or condition resulting in death) heart Congestive Due to (or a onsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show miner must be notified at

the Medical Examiner

"natural",

alth and Mental Hygiene.
27 is marked other than "i

permit. Pages 1 and 2
Department of Health a Important: If item 27 is any Injury or other trains

Director

Funeral

Completed by

Be

and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and burial-trar physician the as use ģ signed by has page this certificate Physician:

P.O. Box 68760,

Division or Vital Records,

funeral dir or Attending within 24 hours area were to the Funeral Director: Aff To the Hospital

Physician/Medical Examiner Completed by To Be

Certification:

Medical yellina

2 Accident

3 ☐ Suicide

4 | Homicide

(Check only one)

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D0050883

20646

1∏Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 25.2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nL 11655

31. Date filed (Month, Day, Year)

AUG 2 8 2007

investigation

6 Could not be determined

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State AUG 2 8 2007 Registrar

29b. Signature and title of certifier

3720 Fort Mead Road Laurel, MD 20736 Gerren Perry, MD 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0059182

29d. Date signed (Month, Day, Year)

07

Examiner Division or Vital Records, P.O. Box 68760.

The law requires that the death certificate be executed burial-trar attending physician as the l for use Hospital or Attending Physician: 4 hours after death.

-uneral Director: After this certifica filled in by

2 Accident

6 ☐ Could not be

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f st any Injury or other traumatic event, the Medical Examiner must be notified.

Physician

/Medical

Baltimore, Maryland 21215-0036

death with the Maryland

	To the I within 2. To the I сотрlet
CR	3
	Sta

Certification: 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) 85929 OHIO 30. Name and address of letson who completed cause of death (Item 23a) (Type, Print)

IACTNTA D ARRINGTON 10 CENTER DRIVE, BETHESDA, MARYLAND JACINTA D. ARRINGTON

31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 8 2007

2007

20892

State of Maryland / Department of Health and Mental Hygiene Aaron Paul Tinsley 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day August 25, 2007 1727 hrs Medical Examiner P. Tinslev Aaron c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince George's Hospital Center Cheverly 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** ForeigWashington, Months Days Hours Director 198 216-19-7937 26 April 14, 1 XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No 28a-f show Prince George's Capitol Heights Maryland with the Maryland 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number notified at ۵ 20743 United States 4217 Quinn Street 23a 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? death . 1 X Never Married 2 Married Yes P hours after Widowed 4 Divorced f Yes. Give Year Yes 2 No specify: Specify Black marked other than "natural", c event, the Medical Examiner <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 I rment of Health and Mental Hygiene.
 rtant: If item 27 is marked other than ", y or other traumatic event, the Medical E MD 21215-0036 12 years Electrician Private 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be A. Paul Tinsley Violet Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4217 Quinn St. Capitol Heights, MD 20743 Violet Tinsley - Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation Removal from State 8/31/2007 Washington, DC Other Specify: Μt Olivet Cemetery Donation 5 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Fun, ral Se vice letcense Benning Road, NE Washington, DC 20019 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician en Onset and failure. List only one cause on each line. Medical Death a Blunt Force Injuries of the Head with Complications Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED tending physician use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death the attending past 12 months? Pregnant at time of death 4 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? After this certificate has performed? ✓ Yes 2 1 🗸 Yes No 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be Other4 examiner? Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Aug 17, 2007 28d. Describe how injury occurred 28c, Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: Subject assaulted 0000 hrs Natural Yes 2 ✔ No Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) 18th Street and California Street, NW, Washington, DC determined (Specify) Local Street 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier August 27, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner

State

ORIGINAL

Registrar

31. Date filed (Month, Day)

07-06648

Richard Edward Treacy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 29152

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Exami	ilei.	4a. Facility Name (if not institution, g 7851 Malcolm Road		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's
Funeral		Social Security Number 6.	Sex 7. Age (In yrs. last bir	Months Days Hours Min.		M/DD/YYYY) 9. Birthplace (State or Foreign Island Country) 1960 Stantan, NY
Director		093 56 8042 1	X м 2 F 47 46	Yrs.	Jan 25	1960 Stantan, NY
ow any		10a. State 10b. County	10c. City, Town	n or Location Houston	10	1 Yes 2 No
aryland	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
h the Mi 3a or 2	l Dire		wood Drive #3	77079 13. Was Decedent of Hispanic Origin? (S	ecify Yes of No-	nited States 14. Race - American Indian, Black,
MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene tem 75 is marked other than "natural", or items 23a or 28a-f show any trampatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X XNever Married 2 Marri	ed Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc. Specify: White
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D 2121 should be I and Mental 7 is marke	9 B		(Type, Print)	19b. Mailing Address (Street and Number or		
MD d 2 shc Ith and n 27 is			acy (Mother)	754 Bateswood Dree of Disposition (Name of cemetery,	ive #3	Houston, Texas 20c. Location - City or Town, State
tore, Mages I and 2 and 6 Health t: If item 2 other traum	ŀ	20a. Method of Disposition 1 Burial 2 X X Cremation	3 Removal from State crem	natory or other place) e Crematory Aug 31	2007	Clinton, MD
e a le le le le le le le le le le le le le		4 Donation 5 Other Spe 21. Signature of Juneau Springer	CITY			ral Homn, Inc 6633
Balti permit. Departr Import		11/1/11/11/11/11	2.10 1000152	Alexandria Forr	v Poad	Clinton MD 20735
hysiciar		23a. Part I. Enter the disease, or confailure. List only one cause of		on not enter the mode of dying, such as cardiac	or respiratory arres	Between Onset and Death
ledica amine		Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic car Due to (or as a consequence of):	rdiovascular disease		
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Box 687 e death certific the attending	1010		nown g Unknown		23e. Did tob	pacco use contribute to the cause of death?
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S, P quires t	3				24a. Was a	
COCC law re	director, page 2 should				perform	med? death?
ial Recian: The	or, pag			26.Place of Death (Che		177
Vital ysiciar this cer	direct	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 E	TVOotpatient o	-	Residence 6 Other: Scene
Division of Vital Records, tal or tequir tal or Attending Physician: The law requir as after death.	tuneral		(Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	200. 5000.150	
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Divisior Hospital or Attene 24 hours after death Funeral Director:	led in	t deter	rmined (Specify)			
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending.			hysician: To the best of my knowledge	e, death occurred at the time, date and place, d/or investigation, in my opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the J vithin 2	comp	(Check only one) 2 Medical Exa 29b. Signature and title of certific	and mainter stated.	29c. License number		29d. Date signed (Month, Day, Year)
		anet) `	O.C.M.E.		August 28, 2007
			who completed cause of death (Item 2	^{23a)} 111 Penn Street, Baltimore, MD 21	201	
		Ana Rubio MD. As: 31. Date filed (Month, Day, Year)				
Reg			1 2007 Benevas Di	. Joseph		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2007 **Physician** 24, 5:25 A^{M} IOLANDA MAFALDA TRICKETT August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year 1 □ M 2 □ F 577-09-6945 90 1916 Pennsylvania Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show la or 28a-f show t be notified at 1 Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 820 Apache Court 21701 U.S.A. "natural", or items 23a or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Clerk U.S. District Court marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F is marked ot Be Pages 1 and 2 should be Frank Fera Mary Bianco ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Brenda Dormer / Granddaughter 820 Apache Court, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery 4 □ Donation 5 □ Other (Specify) 8/29/07 Washington, D.C. permit. 21. Signature of Funeral Service Licens ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. Kull 1201 NORTH MARKET ST., FREDERICK, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or commencations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTIZUCTIVE" NULMORAN DISEMS **Physician** /Medical Due to (or as a consequence of): Examiner FAILUNG Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the a 9□Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Munknown 1 TYes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? page 2 : certificate has Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident nin 24 hours after death the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within (29c. License number 29b. Signature and litle of certifier 29d. Date signed (Month, Day, Year) 0 71111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK 814 Toll House MD 21701 KAZMI Aegistrar's Signal

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:55 P^M 2007 AUG. 25 MELBA MILDRED TULLY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY 16400 BLACK ROCK ROAD **GERMANTOWN** If Under 1 Year If Under 24 Hrs. Months Days Hours Min. MAR 6 Birthplace (State or Foreign Country)
 OH 7. Age (In yrs. last birthday) 5. Sociat Security Number **Funeral** 87 281-16-9430 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r items 23a or 28a-f show intermust be notified at MONTGOMERY GERMANTOWN MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20874 USA 16400 BLACK ROCK ROAD death v Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours efter 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 ö Specify Specify: WHITE þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) SECRETARY MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked of traumatic ever MILDRED FLORENCE BROFFT JOHN PAUL WEBER, SR. Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 19a. Informant's Name/Relationship (Type, Print) 12889 CLIMBING IVY DR., GERMANTOWN, MD t of Health if item 27 i LINDA JOHNSON / DAUGHTER other t 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State MEMORIAL 8/30/07 permit. Page:
Depertment of
Important: If is any injury or 6 CINCINNATI, OH ARLINGTON 4 ☐ Donation _ 5 ☐ Other (Specify) CEMETERY 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86 BARNESVILLE, MD 21. Signature of Mineral Service Licenses 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks CEREBRO VASCULAR ACCIDENT Physician /Medical Due to (or as a consequence of) Examiner years HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): nding physicien P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by page 2 should be 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 No DEMENTIA 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how intury occurred 28b. Time of 27. Magner of Death Intury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral 6 Maching Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and titte certifie 929 W person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 911 RUSSELL AVE., MELNICK, MD GAITHERSBURG,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 8 2007

32. egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** SYLVAN 2007 WERTLIEB 20. AUGUST 6:09 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country)
 RUSSIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Funeral 1 ☑ M 2 ☐ F 579-16-1149 94 DEC 10, 1912 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show MARYLAND MONTGOMERY ROCKVILLE 1X Yes 2 □ No 7 Is marked other than "natural", or Items 23a or 28a-f st traumatic event, the Medical Examiner must be notified Director 10e. Street and Number 9701 VEIRS DRIVE 10f. Zip Code 10g. Citizen of What Country? 20850 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: WHITE δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) filed within Hyglene. 12 LIOUOR MERCHANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAMUEL WERTLIEB BERTHA YUTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun ROBERT BARRY WERTLIEB/SON 9301 WOODEN BRIDGE ROAD, POTOMAC, MARYLAND 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition IX Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GDNS 08/23/2007 OLNEY, MARYLAND 0 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 21. Signature of Funeral Service 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. RESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner SEPTIC SHOCK Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi RENAL FAILURE Due to (or as a consequence of) Box 68760, attending physician certificate be Physician/Medical ASPIRATION PNEUMONIA as the t for use a IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 2XNo 3 Probably 4 Unknown 1 ☐ Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No certificate has Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ∭npatient 2 ER/Outpatient 3□ DOA ို this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: us after death.
Jeral Director: A'
iy filled in by the f 1 Natural 5 Pending Injury 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ulom D0065819 1007 AUGUST alexamela 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) **AUG** 2 4 2007

ALSXANDER

32. Registrar's Signature

CENTER DR

MEDILAL

9901

ORIGINAL

ROCK VILLE

Physician /Medical **Examiner**

and

attending physician for use as the buria

ed by the a detached i

The law requires that the death certificate be executed

or Attending Physician:

Hospital

ပ္

this

within 24 hours after death

To the Funeral Director:
completely filled in by the

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

items 23a "natural", or items 23a

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23.

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other tany injury or other traumatic event, those.

Baltimore, Maryland 21215-0036

be notified

Director

Funeral

2

Completed

Be

Examine Physician/Medical þ Completed Be ၉ Certification:

Immediate Cause (Final disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√No 1 X npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAKHVINDER WADHWA, MD

1 MD

29d. Date signed (Month, Day, Year) D0063498

400 W. 7th ST. FRED. MD. 21701

State Registrar

Medical

distrar's Signature 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Baltimore, Maryland 21215-0	
The state of the s	P
Division or Vital Records, P.O. Box 68760,	

To the Hospital or Attending Physician: The law requires that the death certificate be executed

	i	For State Of Ividi yidii State Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of	Death	2. Date of Death		3. Time of Death		
sician edical miner	4	ta. Facility Name (If not institution, give street and number)	Wantz		r Location of Death	August 2	26, 200 Year 4c. County of Death			
ral tor		8 West Moser Road 5. Social Security Number 214-32-4596 6. Sex 1 □ M 2 ▼ 7. Age (In yrs. 73)	last birthday) Yrs.	Thurmon If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	Frederic 9. Birth 29. Birth 2004 Mary	place (State or Foreign		
	1	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Loc	cation				10d. Inside City Limi		
ral Directo	1	Maryland Frederick Th 10e. Street and Number 8 West Moser Road	tarmone	10f. Zip Code	1788	100	g. Citizen of What Cou USA	ntry?		
once. To Be Completed by Funeral Director	1	11. Marital Status 1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H i Yes, specify Cuba ☐ Yes 2ᡌ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White			
Completed		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give F	ent's Usual Occup kind of work done DO NOT use retired tress/C1	during most of worki d)	ing	6b. Kind of Business/Ir	ndustry		
To Be C	1	17. Father's Name (<i>First, Middle, Last</i>) Ernest Ray Carbaugh	1		18. Mother's Name	Brice	Riden			
	W	19a. Informant's Name/Relationship (Type. Print) Vilbur Wantz/Husband 20a. Method of Disposition 20b. F	8 Wes	t Moser	Road, The	urmont, N				
0	20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Creagerstown Cemetery 8/30/2007 21. Signature of Funeral Service Licensee 22b. Place of Disposition (Name of cemetery) 8/30/2007 Creagerstown, MD 22c. Name and Address of Facility Stauffer Funeral Home, PA									
		23a. Park. Enter the disease, resplications that caused the deat shock, or heart failure. List only one cause on each line.	th. Do not ente	er the mode of dyir	n_Street,	Thurmo	ont, MD 21			
an cal ier		Immediate Cause (Final disease or condition resulting in death) a. Pan (reat Due to (or as a consequentially list conditions, if any leading to immediate Due to (or as a consequentially list conditions, if any leading to immediate Due to (or as a consequentially list conditions).	quence of):	nci				Snowh		
Medical Examiner	Sequentially list conditions, if any, leading to immediate the first function of the fir									
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day Year		
ed by Pł		Part II. Other significant conditions contributing to death but not res	ulting in the un	nderlying cause giv	ven in Part I.		acco use contribute to			
Completed						24a. Was an autopsy perform 1∐ Yes 2	ed? prior to o	opsy findings availa ompletion of cause 2 No		
Medical Certification: To Be Completed by Physician/N		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigation 3 ☐ Suicide 4 ☐ Homicide determined 1 ☐ Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Place of injury - At houilding, etc. (Species)	ER/Outpatient 28b. Time of Injury ome, farm, stre	28c. Inju Wor M 1	ter: 4 □ Nursing Ho ry at rk? Yes 2 □ No	28d. Describe how	nce 6 Other (Spec vinjury occurred seet and Number or Ru			
Medical Co		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my km 2 Medical Examiner: On the basis of examinand manner stated.	owledge, death ation and/or in	n occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)		
. %		29b. Signature and title of certifier		29c. Licens		29	d. Date signed (Month	, Day, Year)		
Mec	-	30, Name and address of person who completed cause of death (Iter			06459	7 6	12814			

		1 - For State Registrar	State of Mar		artment of H rtificate of L			2007	29158
Physic		Decedent's Name (First, Middle, Las Janice Ann Willi					2. Date of Death	25 ^{Day} 2007 ^{ear}	3. Time of Death 8:00 A M
/Medi Exami		4a. Facility Name (If not institution, give			4b. City, Town, or Waldor	Location of Death		4c. County of Dea	
Funeral Director		377 32 0000	7. Age ((In yrs. last birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Sept. Day	,1940 Was	thplace (State or Foreign
Maryland -f ehow	tor	Usual Residence of Decedent 10a. State Maryland 10b. County Charles		0c. City, Town or Lo Waldor					10d. Inside City Limits
h with the 23s or 28s	al Director	10e. Street and Number 4285 Marion Lane	1.		10f. Zip Code 20601		11	0g. Citizen of What C	ountry?
8 TG 21215-UU36 be filed within 72 hours after death with the Maryland hat Hygiene. do other than "natural", or Items 23a or 28a-1 show event, the Medical Exeminat must be rediffed at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1Yes 2No If Yes, Give Year or Dates:	i i	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
VIZIS-UU36 within 72 hours af ene. then "netural; or the Medical Every	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired maker	ation during most of work f)	ang	16b. Kind of Business At Home	/Industry
and Z d be filed v ental Hygie ced other c event, Ib	Be	17. Father's Name (First, Middle, Last) Unavailable				18. Mother's Name Anges B			
Maryland nd 2 should be file slith and Mental Hy 27 is marked oth r treumetic even	5	19a. Informant's Name/Relationship (7) Steve Williams/Son	Гуре, Print) Ω	19b. Mailir 38424	ng Address (Street a Barbara	and Number of Run Ct., Mec	al Route Number hanicsvi	City or Town State	Zip Code) 1659
Baltimore, Marylar permit. Pages 1 and 2 should be Depertment of Heelth and Menta Important: If Item 27 is marked eny injury or other treumetic events.		20a. Method of Disposition Burial 2 Cremation 3 4 Donation 5 Other (Specify		20b. Place of Dispo cemetery, crer Trinity M	sition (Name of matory or other place emorial (ardone	Aug. 29,	20c. Location - City of Waldorf, N	
Dantit. Depertment imports eny inju		21. Signature of Funeral Service Licen	list III				nsfield-	Echols F.H	
Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line a.	le death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
/Medical Examiner	_	Sequentially list conditions, if any, leading to immediate	b	consequence of):					
ecuted end I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):					
68 / 6U, ficate be executed physicien end ts the burial-transit	edical E		d						
Geath certifications of for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
ecords, P.O. law requires thet the as been signed by th	Ď	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause givi	en in Part I.			to the cause of death? Probably 4 Denknown
The The page	Completed						24a. Was a autops perform	ned? prior to death?	utopsy findings available completion of cause of s 2 No
Of VITAL Physician: The this certificate rai director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	26. Place of Deat			
g Physical dispersed dispe	 -	27. Manner of Death	28a. Date of Injury (Month, Day)	2 ER/Outpatier 28b. Time o	IL SELIDON	4 La Nursing no		ence 6 Other (Sp ow injury occurred	ecity)
DIVISION OF all or Attending Phy after death. I Director; After this din by the funeral d	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At home, farm, str	M 1 🗆	Yes 2 □No	28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
DIVIS To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by t	Medical Ce	(Check only 2 Medical Exam	ysician: To the best of niner: On the basis of e	xamination and/or in	h occurred at the tin	ne, date and place, pinion, death occur	and due to the carred at the time, d	ause(s) and manner a ate and place, and du	is stated. le to the cause(s)
To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner state	gu.	29c. Licens	e number	2	9d. Date signed (Mor	nth, Day, Year)
		In Jak	a By	ナ		5482	0	08/27/20	207
333		30. Name and address of person who was a family and the same and address of person who was a family and a family a family	1thcare	1550c. 10	2070 01a	Line Ct.	#100	Walderf	MD 20602
St Regist	ate rar	AUG 2 7	32. Reofirar 2007	w &	books				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 9871 9-19-07 vt.
State of Marylane? Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Mary Constance Wright 4.08 AM AUGUST 2007 23 Mary Connie Wright 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CECIL UNION HOSPITAL OF CECIL ELKTON COUNTY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 X I Months 217-40-7988 63 Feb. 24, 1944 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 688 West Old Philadelphia Road 21901 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNO If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify Specify: White Ş A 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Distribution 12 Service Distribution Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fahrney Fox Ellen Suter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 9 0 1 19a. Informant's Name/Relationship (Type. Print) Ronald Wright / Husband 688 W. 01d Philadelphia Road, North East, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 1 ☐ Burial 2 X Cremation Other (Specify) Mayerdale Crematory 27, 2007 Newark, Delaware 4 □ Donation 21. Signature of rvize L 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PLILMONARY unknown Due to (or as a consequence of): PNEUMONIA unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknowr 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760. P.O. I Division or Vital Records,

executed attending physician and for use as the burial-transit certificate be signed by the a d be detached for completely filled in by the fureral director, this of or Attending Phase the sector: A terth To the Hospital within 24 hours Hospital

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

marked other than "natur matic event, the Medical

Department of Health Important: If item 27 any Injury or other tr once.

Physician

/Medical

Examiner

I and 2 should be fil Health and Mental H Im 27 is marked otl

Pages 1

the

Funeral

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of cert

Medical

106

29c. License number D 63486

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

AUGUST, 23, 2007

on who completed cause of death (Item 23a) (Type, Print) , EUKTON, MD 21921 M.A. HAMADEH BOW STREET

32. Registrar's Signature

			For State	S	State of N	<i>l</i> larylan					id Men	tal Hyg	jiene			
			Registrar	-1-11- 141			Cei	rtificate	e or L	Jeath	T 0 F	Date of Dea	eg. No.2	007	29160	_
	Physici	an	1. Decedent's Name (First, M		TERS	3					1	Month	Day	Year	4:12 AM	
-	/Medio		4a. Facility Name (If not institu					4h City	Fown or	Location of D		28	23 40 Co	2007 ounty of Death	1.12 A.	_
	Examin	er												tgomery		
14	Funeral		Washington A 5. Social Security Number	6. Sex	7.	Age (In yrs.	last birthday)			rk If Under 24	Hrs. 8. [Date of Birth	1	9. Birthp	lace (State or Foreign	_
L	Director		225-20-7424	1 □ M	2 ∑ F	81	Yrs.	Months	Days	Hours I	Min. oct	Month, Day 24, 19	925	Coun VA	try)	
	pu ,		Usual Residence of Decedent			10a Cit	v. Town or Lo	nation						T	0d. Inside City Limits	_
	aryla shov	7	10a. State 10b. Cou	u.											1 □ Yes 2 No	
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	ns 23 mus	Funeral Director	11. Marital Status		Was Decede	nt Ever in U.	.S. 13.		0906 lent of Hi	spanic Origin n, Mexican, P	? (Specify	Yes or No-	US	A. Race - Americ	an Indian,	_
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 □ Never Married 2X 1 3 □ Widowed 4 □ Divor		Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date:] No	1	If Yes, spec 1 ☐ Yes		n, Mexican, P Specify:	ouerto Rica	n, etc.)	sı	Black, White, opecify: Whi		
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21215-0036	within 7 iene. • than "n the Medi	Completed	(Specify only hi	1	College (1-4c	or 5+)	life.	DO NOT us	e retired, naker	luring most of)	r working		Own	Home		
	other other /ent,	BeC	17. Father's Name (First, Mid	ille, Last)			1			18. Mother's	Name (Fir	st, Middle,	Maiden Su	ırname)		_
Maryland	uld be Venta rrked ric ev	ToE	John Smith	l .						Maude	Wo	oltz				
<u>a</u>	2 sho and I is ma auma		19a. Informant's Name/Relat	onship <i>(Type</i> .	Print)		19b. Maili	ng Address	(Street a	and Number o	or Rural Ro	ute Numbe	r, City or T	own, State, Zip	Code)	
	and and n 27		Edward M. Waters	/Husba	end		15100	Glade	Drive	e, Apt 2	D, Sil	ver Sp	ring,	MD 20906		
Baltimore,	ges 1 t of H If ite or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati	on 3∐Rem	oval from Sta	0	Place of Dispo emetery, cres DECK	osition (Nan matory or o	ne of ther plac	e) :	Date		20c. Local	tion - City or To	wn, State	
<u>#</u>	tmen tant: tant:		4 □ Donation 5 □ Othe			Mem	orial P				27, 2	2007	Olney,	MD		
Bal	Departiment of the control of the co		21. Signature of Funeral Ser	ice Licensee	2.2		1								Home, Inc.	Į
			23a, Part1, Enter the disease	or complicat	ions that caus	sed the deat				7 Blvd W				D_20901	Approximate	
	Dhysisian		shock, or heart failure. Immediate Cause (Final		cause on each	line.			· - , ,	9,		,	,		Interval Between Onset and Death	J
	Physician / /Medical		disease or condition resulting in death)	a		NEU S as a conseq	MONII	٦.	_							
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Bo	eath atten for u	cian	23b. Was decedent pregnant in the past 12 months?		1 ☐Live birth	2 🗆 Feta	al death 3	☐Ectopic pr☐Other (sp					230	d. Date of delive Month	Day Year	
o.	the d y the sched	iysi	1 ☐ Yes 2 ဩ √no 9 ☐ Unknown		9□Unknowr											
Division or Vital Records, P.O. Box	uires that the death certific signed by the attending p d be detached for use as	by Physician/M	Part II. Other significant con	ditions contrib	outing to death	n but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did to			ne cause of death?	1
Ö	w requir been si should	Completed									_	24a. Was a	[
Re	he law has ge 2 a	ᇤ									-	autop		prior to cor death?	psy findings available mpletion of cause of	
ā	in; Ti ificate or, pa		25. Was case referred to me	lical						26. Place of			2 No	1 ☐ Yes	2 □ No	_
Ē	hysician ; The Is his certificate had I director, page 2	o Be	examiner? 1 Yes 2 No		pital: 1 🗀 Knpa	atient 2 □	ER/Outpatie	nt 3 □ DO	A Othe	27'				☐Other (Specif	ν)	_
0	g Phy er thi	اۃا	27. Manner of Death		28a. Date of I		28b. Time o	of 2	8c. Injury Work			Describe h			<u>/</u>	_
Ö	ath. pr: Aff	atio	Z	estigation	(INIO/IIII),	bay rour,	injury	M		Yes 2 □ No						
Divis	after de after de Directe	Certification: T		uld not be ermined	28e. Place of building,	injury - At ho etc. <i>(Sp</i> ec <i>if</i>	ome, farm, st	reet, factory	, office			Location (S City or Tow		Number or Rura	l Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier 1 > ert (Check only one) 2 Med	fying Physic cal Examine	ian: To the be : On the basis and manner	s of examina	owledge, deat ation and/or ir	th occurred evestigation	at the tin , in my o	ne, date and p pinion, death	place, and occurred a	due to the out the time,	cause(s) ar date and p	nd manner as s lace, and due to	tated. the cause(s)	
	o the	Me	29b. Signature and title of ce	tifier				290	. License	e number			29d. Date s	signed (Month,	Day, Year)	-
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•	D		30. Name and address of per		•	f death (Iten	n 23a) (Type,						. 1	,		
			KAJAL DAS (31. Date filed (Month, Day,)	OPTE	76	00	CARO	LL A	NE	OTA	K014	A PF	1RK	, M.C	20912	-
	Sta Registi		AUG 2	7 2007		Mar 1	ature	SOF	*							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Wilma Jean Warner August 18 2007 Р /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12502 Blue Valley Road Allegany Cumberland If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F 77 Yrs. 215-26-7663 03/03/1930 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 Yes 2 No MD Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 202 Memorial Avenue, Apt 1B Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: \$ Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) the Clerk Hotel 12 other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil ment of Health and Mental H :ant: If item 27 is marked ott Be Richard Byrd Anderson Helen Louise Baker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. Shawnee L. McElfish /Daughter 12502 Blue Valley Road, Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Cumberland Crematory 08/21/2007 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Fyneral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD Mans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA METASTATIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusito (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe 1 Yes 2 No 3 Probably 4 ✓Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy 1∏ Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Klother (Specify) Residence 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 7 Natural 5 Pending Injury 1 □ Yes 2 □ No hours after death. investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred at the content of t 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only manner stated. one) the

3 nds

2

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year) AUG 2 1 2007

Qamar U. Zaman, M,D,m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c, License number

D0023371

29d. Date signed (Month, Day, Year)

21502

August 20, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARIE WILKINSON 100 8h 2007 2^{Day} 1:45A M /Medical 4a. Facility Name (If not institution, give street and number)
Prince Georges Hospital 4c. County of Death Prince Georges Examiner 4b. City. Town, or Location of Death Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 04/15/1945 1 M 2 1 F 62 577-58-2016 Washington, DC Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits Director MD Prince Georges Greenbelt 1 TXYes 2 □ No 10f. Zip Code 20770 10e. Street and Number 10g. Citizen of What Country? with r than "natural", or Items 23a or the Medical Examiner must be #204 6632 Lake Park Drive USA Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Wivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) filed withii Hygiene. Assistant Private Administrative permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other tha any injury or other traumatic event, the I once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Bentley Jack Mathis 2 19a. Informant's Name/Relationship (Type. Print)
Kevin Hood Son Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10400 Drumm Ave Kensington, MD 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Fort Lincon Cemetery 08/31/07 Brentwood, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sp ^{22. Name and Address of Facility} Bianchi 814 Upshur ST NW Wash, DC 20011 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septicemia /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed Metastatic Lung Cancer physician and is the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 20 Unknown Be Completed page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No has autopsy certificate perform 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 🛮 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To 2 ☐ ER/Outnatient this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending (Month, Day Year) 12 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No death 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ophnell Cumberbatch 3001 Hospital Dr. Cheverly, MD 20985 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 8 2007 Registrar

			State of Maryland / Department of Health and N Certificate of Death	_	giene Reg. No.	07	29163
	Dhysisis		1. Decedent's Name (First, Middle, Last)	2. Date of De Month	eth Dey	Year	3. Time of Death
	Physicia /Medic	al .	Mary Jo Weissenberg 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Li	August	27 4c. County	2007	1:15 a.m.
	Examin	#I	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or D Sacred Heart Home Nursing Center Hyattsvil		1		eorge's
_			5. Social Security Number 6. Sex 7. Age (In vrs. lest birthdey) If Under 1 Year If Under 24 Hrs.				lace (State or Foreign
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5	mit. Pa partmen portant: y injury ice.	1	21. Signature of Funeral Service Licenses 22. Name and Address of Facility		9 Balti		
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	Ti.		23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory e	rrest,	-	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final	^			Onset and boats
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	n 24 h	edical	(Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occur and manner stated.	rred at the time,			
	To the To the Company	Ž	29b. Signature and title of certifier 29c. License number		29d. Date signe	ed (Month,	Day, Year)
7			May 1, 197609.		8. a	1-0	/
1	(6)		30. Name and address of person who completed cause of death (Herr 23a) (Type, Print) PAMAN 3 SO 3 PERRY STREET, MOUNTRAINER: N	KITO	JLI.	MD	
P	Stat	ρ.	31. Date filed (Month, Ley, Year) 32. Registrer's Signature ;	DILLY	LAND	20	712
	Registra		31. Date filed (Month, Ley, Year) AUG 2 9 2007 Security D. Specific				

DHMH 16 Rev 6/95

ORIGINAL

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760. attending physician

Funeral

Director

items 23a or 28a-f show ner must be notified at

"natural", or item edical Examiner r

injury or other traumatic event,

permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If item 27 Is marked other than "natural", or ite

with the Maryland

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Baltimore,

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certificate

24 hours a e Funeral I

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Medical

State

29b. Signature and title of certifier

MERNANDO 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
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25. Was case referred to medical	26. Place of Death (Check only	v one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital:	sidence 6 □Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury Work? n M 1 ☐ Yes 2 ☐ No	e how injury occurred
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At nome, farm, street, factory, onice 28f. Location	_(Street and Number or Rural Route Number, own, State)
29a. Certifier 1 Certifying P	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time	ne cause(s) and manner as stated. ne, date and place, and due to the cause(s)

29c. License number

00041211

100 E. Carrou ST. SAlisbury, Md. 21801

29d. Date signed (Month, Day, Year)

Registrar

BA10-11

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			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	uncau	e OI L	Jeam		2. Date of De			, ,	3. Time of Dea	
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	Examin		4a. Facility Name (If not institution, give	street and numbe	or)		4b. City,	Town, or	Location o	f Death	0	4c	. County o	f Death		
			Fahrney Keedy Nu 5. Social Security Number 6. Se			last birthday)	B If Under	OODS	boro If Under:	24 Hrs.	9 Date of Bir	dh	Wash:	ingto	n Count	y reign
	Funeral Director			M 2□F	-ge (m yrs. 88		Months	Days	Hours	Min.	8. Date of Bid (Month, Da Feb 4	y, Year) 191	19		ace (State or Fo ry) Cyland	orgin
	pu ,		Usual Residence of Decedent 10a, State 10b, County			v. Town or Lo	antion								d. Inside City Li	mite
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	r 28e-	rect	10e. Street and Number				10f. Zip					10g. Cit	tizen of W	hat Count	ry?	
	239 o	alD	8507 Mapleville	Road					21713					U.S.		
	er de s	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Anned Force: 1 Yes 2	s?	10 /1			spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	0-	14. Race Black	, White, e	tc.	
939	el', or	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates	12	-13-41 -22-45	1□Yes 2	ZA No	Specify:				Specify:	Wha	ite	
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21215-0036	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene and other then "natural", or items 23e or 28e-f show do other then "natural" Examinar must be notified at event, the Madical Examinar must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4o	or 5+)		echan	-	1			F	Priva	te So	chool	
מַ	A - 0 5	Be C	17. Father's Name (First, Middle, Last)								(First, Middle)		
Maryland	2 should be and Menta is marked eumatic ev	To	James Vincent Ze								rva Kin					
Mar	d 2 sh th and 7 is m treum		19a. Informant's Name/Relationship (7) Kimberly Stine - (•				≀Route Numb oad Hao				Land 217	74 <u>0</u>
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Ē	Pages nent of int: If it iry or o		¹A☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)			Pauls	Ceme	tery	3		-2007			-	ng Maryl	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke eny injury or other freumetic ODES.		21. Signature of Funeral Service Licens	Zin		13	Name an	d Address	s of Facility n B1v	y SDo vd. N	ouglas V. Hage	A. Fersto	Fiery own M	Fune aryla	eral Hon and 2174	ie 12
п			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caus	ed the deat	h. Do not ent	er the mod	e of dying	, such as	cardiac o	r respiratory a	arrest,			Approximate Interval Betwee Onset and Deat	
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	/Medical Examiner		Tosuming in doday	Due to (or a	as a consed	uence of):										
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on of	ding Phy h. After thi funeral		27. Manner of Death 1 → Natural 5 □ Pending	28a. Date of Ir (Month, L	njury Da <i>y Year)</i>	28b. Time of Injury	M 2	8c. Injury Work	at ? ∕es 2⊡!		28d. Describe	how inju	iry occurre	bd		
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5	tel or A rs after el Direct led in by	Cert	4 Homicide	building,	etc. (Specif	y) 					City or To	wir, Stati				
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5 F	1-4+1		30. Name and address of person who co	II a-6		CCo U	·+ 1	lace	erst	الدن	, MI	2	ーノフト	12		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 12:40 AM Beatrice Anderson September 9 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Baltimore NA Baltimore SIMM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 💥 □ F 212-30-5956 78 Director 5-24-1929 Ga. Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3542 Elmley Avenue 21213 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Menta. Hygiene. Int: If item 27 is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced Black Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10th grade College (1-4or 5+) Domestic Cook Department of Health and Menta Hygin Important: If item 27 is marked cither any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dock Martin Izzie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Blake 3542 Elmley Ave., Baltimore, Md. Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Qonation 5 ☐ Other (Specify) Md. Vet Cemetery Qonation 5 Other (Specify) 9-14-07 Crownsville, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. Enter the disease, or complications that caused the learnest point enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 21202 Approximate Interval Between Onset and Death art sho e Cause (Final or condition in death) Physician Binany Pen formal /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtal-transit completely filled in by the tuneral director, page 2 should be detached for use as the burtal-transit attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an his certificate has bil director, page 2 s performed. 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

\$

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

SUZanne Jiz

31. Date filed (Month, Day, Year)

2411

MD

32. Registrar's Signature

Belvidne

mu an

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

000

RES

Avenue

29d. Date signed (Month, Day, Year)

Suite 2016 Ball more MD 21215

September 9, 2007

07-07017 Carl Abernathy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

an Abematny		1- For State	e of Maryland /		irtment of <i>tificate of</i>		nd Menta	_	200	7 2916
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any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits
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ours af atural	d by	15. Decedent's Education (Specify	l or Dates:	pleted)	16a. Decedent	's Usual Occup	ation (Give kir	nd of work done	16b. Kind of Business/	Industry
n 72 hc	oleted	Elementary/Secondary (0-12)	College (1-4 or 5	i+) .	during mo	st of working lif		se retired)		
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y, MD 21215-0036 and 2 should be filed within 72 fealth and Mental Hygiene. Item 27 is marked other than traumatic event, the Medical	ှင	19a. Informant's Name/Relationship							mber, City or Town, State	
and 2 sho ealth and em 27 is		Carl Gene Abernath 20a. Method of Disposition	y (Father)	20b. F	1708 I			Apt.B3 E	Baltimore, Ma	ryland 21222
more Pages 1 ent of H nt: If i		1 X Burial 2 Cremation 3 4 Donation 5 Other Specia	ify:	ا ا	rematory or oth	er place) Mem. Ga.	rdens !	9/12/2007	´	T II
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Physician /Medical		failure. List only one cause on	each line.				1.	1.77 1		Approximate Interval Between Onset and
kaminer		Immediate Cause (Final disease or condition resulting in death)	a. Intracerebr			associate	ed with o	cocaine into	xication	Death
		Sequentially list conditions,	b					. • (
	mine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse c.	equence of	f): `		-	- 1		
1	ä	events resulting in death) Last	Due to (or as a conse	equence of	n):					
O, e be ex sician burial	Medical	XUNPENDED	#23a,27,28a	-f, pe	erME,g872	, 10/2/07	TT			
	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	1 Live birth 4 Pregnant at	ne of pregr	2. Fet	aldeath 3 er (Specify)		pregnancy	23d. Date of deliver Month	y Day Year
D. Bc	Ä	Part II. Other significant conditions	9 Olikilowii	but not re	esulting in the u	nderlying cause	given in Part	1 23e Did t	obacco use contribute to	the cause of death?
S, P.C wires that n signed l	হ						9	1Ye	es 2 No 3 Pro	oably 4 🗸 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should led in by the funeral director, page 2 should	Completed							24a. Was auto perfo 1 🗸 Yes	psy prior to prmed? death?	utopsy findings available completion of cause of es 2 No
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f Vit Physic er this ral dire	ို	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier		ER/Outpatient 28b. Time of In		Other ₄ I	Nursing Home 5	Residence 6 Othe	r:
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Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	2 Accident Investiga 3 Suicide 6 XCould no 4 Homicide determin	ation 28e. Place of Injury		unk ome, farm, stree			28f. Location	Street and Number or Ru State) ndalk Ave. Dun	ral Route Number, City
Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Physic	ician: To the best of my	/ knowledg				e, and due to the cau	se(s) and manner as state and place, and due to the	ed.
To with To con	Me	29b Signature and title of certifier	and manner stated.			29c. Licer	ise number		29d. Date signed (Mo	nth, Day, Year)
		Pater leson	i-Yollet	LW		0.0	.M.E.		September 10, 2	:007
X		30. Name and address of person who Patricia Aronica-Pollak M				111 Penn 9	Street Ralt	imore, MD 2120)1	
<i>∖</i> U Sta	te				- A	. I I elli s	rueet, Dall	WID 2120	···	
Registr	ar	31. Date file SEP Page 200	1 person	Je de	July					

Please Type or Print in Black Indelible Ink, Assure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene 0 0 7

29168

						Certificate	e of Death		Reg. No.	• .	45.00
П	Dharaisi		1. Decedent's Name (First, Middle, L	ast)				2. Date of De	eath	Voor	3. Time of Death
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	Examir		4a. Facility Name (If not institution, g	ive street and number)				or Location of Deat	Y		1.00
			Future Care N 5. Social Security Number 6.	urging He	omo To	ab	- 1	,	Balt:	imore	
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last b	irthday) If Under	1 Year If Under 24	Hrs. 8. Date of Bi Min. (Month, D	th		ce (State or Foreign
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			Usual Residence of Decedent					04/00/	1929 1	агута	na .
	show		10a. State 10b. County		10c. City, Tox	vn or Location				100	I. Inside City Limits
	Man	ğ	Maryland Baltim			Gwynn O	ak				1 ☐ Yes 2 【XNo
	# 158 E	Director	10e. Street and Number	ore		10f. Zip			10g. Citizen of V	Vhat Country	0
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Maryland 21215-0020	and and is ma	89 A	19a. Informant's Name/Relationship	(Type, Print)	19	o. Mailing Address	(Street and Number o	r Rural Route Numb	er, City or Town,	State, Zip C	ode)
	1 end 3 Health em 27 i		Walter Allen / H	lusband	7	203 Seym	our Place,	Gwynn Oa	k, Maryl	and :	21207
ore		. 3	20a. Method of Disposition	7B	20b. Place of	of Disposition (Namery, crematory or other	e of	Date	20c. Location -		n, State
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	. [30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, Print)		10 : .	1		
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	4		31. Date filed (Month, Day, Year)	Pell MD	22	Mai	, 5t.	Keiste	stan	MD	21136

			For State Registrar	State of Maryla	and / Depa <i>Ce</i>	artment of F rtificate of	lealth and N <i>Death</i>	ental Hyوا ا	giene Reg. No. 20	07	29169
9	Physici	an	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic	al	Theresa 4a. Facility Name (If not institution, given	M.	Во	rgyon	r Location of Death	SEPT	4c. County	2007	1400 PM
)	Examin	er	SAINT AGNES 5. Social Security Number 6.5	HOSPITAL	rs. last birthday	BALTIN	NORE	8. Date of Birt			laco (State or Foreign
14	Funeral Director			1 □ M 2 □ X F	44 Yrs.	Months Days	Hours Min.	(Month, Day	v. Year)	Cklah	lace (State or Foreign try) Ma
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	th the or 28a e notii	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	ath wil	ral	1234 Pine Heights			2122			USA		
	ter dea items ner m	Funeral	11. Marital Status 1 ☐ Never Married 2 [X Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 [XNo	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Blad	ce - America ck, White, e	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If of Health and Mental Hygiene. If the Z1's marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specif	y: Whi	te
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/au	2 sho and I Is ma		19a. Informant's Name/Relationship			ng Address (Street					,
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Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice		c c	2. Name and Addre	ss of Facility uneral Ho	ome Of D	undalk,	P.A.	
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ပ္တဲ့ မ	e law r nas be e 2 sh	Completed						24a. Was a	sy	prior to con	osy findings available npletion of cause of
								perfo	2 No	death? 1 ☐ Yes	2□ No
	Physician: r this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	er:			(0'/	A
סר	ding Phys h. After this funeral dir	\vdash	27. Mann Death	28a. Date of Injury (Month, Day Year,	28b. Time o			ome 5 ☐ Resid			9
Sior	tendin sath. or: Af the fur	atio	1	n	, injury		Yes 2 □ No		_		
Division or	al or Att after de I Direct d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		t home, farm, st ecify)	reet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	l Route Number,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Pl (Check only one) 1 Medical Exa	nysician: To the best of my k miner: On the basis of exam and manner stated.	nowledge, deat ination and/or ir	th occurred at the til nvestigation, in my o	me, date and place opinion, death occu	, and due to the orred at the time,	cause(s) and made,	anner as sta	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	1		29c. Licens	e number		29d. Date signe	d (Month, L	Day, Year)
	0		1/6	PGYT	I MID	Pa	0654		SEPT.	09	2007
	\		30. Name and address of person who	completed cause of death (II	tem 23a) (Type,	Print)	A				
	, C1-	10	31. Date filed (Month, Day, Year)	TPUTA GO 32 Registrar's Sig	nature Sa	WTH CAT	ONAVENO	or, B	Lrimen	=, N	2007 1D 21229
	Sta Registr		SEP 122	UU/ Januaria	ST ST						

RORGYON, THERESA

			For State Registrar	State of Ma	aryland .		artment of F		nd Mental Hy	/giene	2007	29	170
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Mat	A.	Bro	oKs			2. Date of D Month Septemb	Day	Year 2007	3. Time of 5:00	Death M
,	Examir Funeral		4a. Facility Name (If not institution, give s Suburban 5. Social Security Number 6. Sex	HOSP 7. Age	o; tal	birthday)	4b. City, Town, of Beth of Under 1 Year	Sda If Under 2	4 Hrs. 8. Date of Bi	1	County of Death 100+90 9. Birthp	place (State o	or Foreign
	Director		2.44-52-9648 1□ Usual Residence of Decedent 10a. State 10b. County	M 2 B F	76 10c. City, T	Yrs.	Months Days	Hours	July 2	1,193	1/4 = 1	Caro	
	with the Mar a or 28a-f sh t be notified	Director	Maryland Montgo 10e. Street and Number 6121 Montrose	mery e pand		OCK	10f. Zip Code	752		10g. Cit	izen of What Cour	1 ☐ Yes	2 ⊠ No
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at ea.	by Funeral		12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates;	Ever in U.S.				in? (Specity Yes or N Puerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Black		
Maryland 21215-0036	d within 72 hou giene. r than "natura the Medical E	Completed	15. Decedent's Edur (Specify only highest grade	cation e co <i>mpleted)</i> College (1-4or 5		6a. Deced (Give life. I	dent's Usual Occup kind of work done DO NOT use retired TEAC	during most (d)	of working		ind of Business/Ind		School
ryland	2 should be file and Mental Hy is marked othe raumatic event,	To Be C	17. Father's Name (<i>First, Middle, Last</i>) RUSSell 19a. Informant's Name/Relationship (<i>Ty</i>)		dam		an Address (Street	L	s Name (First, Middle or Rural Route Numb	Le	rach	Code	
_	Pages 1 and 2 s nent of Health an int: If item 27 is 1 iry or other trau		B. Warren Brook 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ R	25	20b. Place	e of Dispo etery, crer	9 ASh/a	wn Cou	Date Date	field 20c. Lo	Va. 22 ocation - City or To	own, State	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License R B B	oku Jr	Reorg	22	Shington Co Name and Addre Ninn Funer	ss of Facility	2/15/07 cc 2605 s.s		amus , 1 gton Road Ar		
	Physician /Modical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	l	Ca	00 not ent	er the mode of dyir					Approximate Interval Bett Onset and I	e ween
wedical Examiner bhysician and bhysician and sthe burial-transit	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or a) Due to (or	a consequen	ce of);								
P.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal de	ath 3□	Ectopic pregnancy Other <i>(specify)</i>	у		At:	23d. Date of delive	•	Year
	w requires that been signed by should be deta	by	Part II. Other significant conditions con	itributing to death bu	ut not resultin	g in the ur	nderlying cause giv	ren in Part I.			use contribute to tl ☑No 3 ☐ Prot		
Division or Vital Records,	The ate h page	Completed	OF Wassess referred to made at						1 Yes	opsy ormed? 2 🔀 No	death?	psy findings ampletion of ca	available ause of
Ž	Physicia this certi al directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital:	nt 2 ER	/Outpatien	t 3 DOA Oth	or.	of Death <i>(Check only</i> sing Home 5 ☐ Res		6 □Other (Specif	iv)	
o uc	Attending Physician: r death. ector. After this certific: by the funeral director,		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injur (Month, Day	ry 28 / Year)	b. Time of Injury	Wor		28d. Describe	how injur	ry occurred		
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide a investigation 6 ☐ Could not be determined a length of the second injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	Hospit 24 hour Funera etely fills	Medical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best oner: On the basis of and manner sta	examination	and/ar in	continution in man	deadle action	a a a a command a A Alon a Africa	4 . 4 .			5)
	To the within To the Comple	Me	29b. Signature and title of certifier				29c. Licens	e number	95 rad Beth	29d. Dat	te signed (Month,	Day, Year)	
•			30. Name and address of preson who co	S. Willes	eath (Item 23	a) (Type,	Print)	1001	10		4/10/0	/	
	10		Steven Wilk 31. Date filed (Month, Day, Year)	<s 8<="" th=""><th></th><th>old</th><th>Georgeto</th><th>wn Re</th><th>ad Beth</th><th>esda</th><th>L, Marylo</th><th>and 20</th><th>1814</th></s>		old	Georgeto	wn Re	ad Beth	esda	L, Marylo	and 20	1814
	Sta Registr		CED 1 9 20	107 Della	and Signature		Willes !						

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State of Maryland / Department of Health and Mental Hygie 20 17

_			1 - State Registrer 1. Decedent's Name (First, Middle,	State of Ma	arylariu ————		tificate of		th		Reg. No.		
ď	Physic		Brace		roo	KK				Month	Day	f	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, g				4b. City, Town, o	r Location	on of Death	sep	4c.	7 2007 County of Death	1118
			212 KIRBY COUR				ODENTY	DNI			1	NNE ARUNI	DEL
	Funeral Director		5. Social Security Number 218–98–3586		e (In yrs. las 40	st birthday) Yrs.	If Under 1 Year Months Days		der 24 Hrs. rs Min.	8. Date of Bir (Month, Da JAN . 1			lace (State or Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation					1	0d. Inside City Limits
	the Marylan 28a-f ahow notified at	to	MARYLAND ANNE AF	RUNDEL		OD	ENTON						1 ☐ Yes 2 X No
	with the Maryland a or 28a-f ahow	Director	10e. Street and Number 10f. Zip Code 10g. 0						10g. Citi	zen of What Coun	try?		
	23a c										U.S	J.S.A.	
21215-0036	hours after death turai', or items 23 al Examiner mus	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ঐDivorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No			cify Yes or No lican, etc.)	i	14. Race - Americ Black, White, Specify: BLAC	etc.
Ö	72 hours natural',	Completed	15. Decedent's	Education		16a. Deced	ent's Usual Occup	ation				nd of Business/Inc	
21	C 2	nple	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5	+)	life. D	ent's Usual Occup kind of work done O NOT use retired	during m d)	nost of working	g			
	be filed withintal Hygiene.			5+		EQUIT	Y ANALYS					AL ESTAT	E
Maryland	2 should be filed v and Mental Hygie is merkad other i raumatic event.	Be	17. Father's Name (First, Middle, La: OZEA BROOKS	st)					other's Name (Sumame)	
Ž	s 1 and 2 should f Health and Men itam 27 is marka other traumatic	2	19a. Informant's Name/Relationship	(Type Print)	-	10h Mailin	Addross /Street		ENDOLY			Town, State, Zip	0.41
Z	nd 2 sulth an 27 is rtrau		OZEA BROOKS (FA									MD 2104	
ē,			20a. Method of Disposition		20b. Plac	e of Dispos	ition (Name of atory or other place		Da			cation - City or To	
Ĕ	A 0		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State			MATORY	<i>(</i> 9)	9–11–2	2007	САТО	ONSVILLE	MD
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lic	auma	72010	LW.	Name and Address TZKEFUNE 55 TWINE	ss of Fac TRAL	HOMES	INC.		A. MD 210	
68760,	The law requires that the death certificate be executed XI W W W W W W W W W W W W W W W W W W	dical Examiner	23a. Part1. Enter the disease, or co-shock, or heart failure. List online the control of the con	a.	consequent	nce of):	Lewey.					tien	Approximate Interval Between Onset and Death
P.O. Box 6	res that the death certifi signed by the attending be detached for use as	Physician/Medical	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 10 □ Unknown	2 ☐ Fetal de	ath 3 🗆 E	Ectopic pregnancy Other (s <i>pecify)</i>				2.	3d. Date of deliver Month	y Day Year
	w requires that been signed should be det	þ	Part II. Other significant conditions	contributing to death bu	t not resultin	ng in the und	derlying cause give	en in Par	rt I.	23e. Did to		se contribute to the	e cause of death?
I Records,	hysician: The law re his certificate has bee I director, page 2 sho	Completed								24a. Was a autop perfor	sv	24b. Were autop prior to com death?	sy findings available apletion of cause of
Vital	cian; ertific actor,	Be (25. Was case referred to medical examiner?						ce of Death (-		
of	- + - 12	atlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day)	281	Outpatient b. Time of Injury	28c. Injury Work	at	28	d Describe h	ow injury	Other (Specify, occurred	rexhaust
Division	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	Certification;	3 Suicide 6 □ Could not 4 □ Homicide determined	building, etc.	y - At home (Specify)	, farm, stree	et, factory, office				treet and	Number or Rural	Route Number,
	the Hospi hin 24 hour tha Funar npletely (ill	Medical	29a. Certifier (Check only one)	hysician: To the best of miner: On the basis of and manner state	examination	dge, death of and/or inve	occurred at the tim stigation, in my op	e, date a pinion, de	and place, and eath occurred	d due to the c at the time, c	ause(s) a late and p	and manner as sta	tod
	To th withir To th comp	Ň	29b. Signature and title of certifier	R	Dep	11ty	29c. License	number O 4	054	7 2	9d. Date	signed (Month, D	ay, Year)
	10		30. Name and address of person who	completed cause of dea	Ca	a) (Type, Pr	int)	15	A	neri	CH	12/7	735
	Sta * Registr	16	31. Date filed (Month, Day, Year) SEP 1 2 2	32 Registrar	's Signature								

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

SEPTEMBER

Day

Year

U. S. A.

Black, White, etc.

23d. Date of delivery

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No

Month

Specify:

14. Race - American Indian,

White

Baltimore

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2X No

Maryland

10.2007

4c. County of Death

Ø9:55A

1. Decedent's Name (First, Middle, Last)

John William Bauernschmidt, Jr.

Physician

/Medical

the Hospital or Attending Physician: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 TYes 2 TNo 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier MD 29c. License number

29d. Date signed (Month, Day, Year) 9-10-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD L LINTHICUM. M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 32. Registrar's Signature

D31826

31. Date filed (Month, Day, Year) State

SEP 1 2 2007

JICHM

DHMH 17 Rev 1/2001

5

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#19b perFH G871 9/12/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year SE RAWN SEPTEMBER 9.20 AM 7 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 1000 SAMARITAN HOSPITAL DALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 212.20.4267 Year) 1 □ M 2 XF 88 Director 02 18/19/19 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 Is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltinzore 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4700 Harford Road 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No f Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Black Completed by Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore College (1-4or 5+) Elementary/Secondary (0-12) notodian City Schools 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Monique Sadie William Saunders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Busie Ashleu aughter Greenlea Drive Pikesville, MD 21208

20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Timonium, MD allei 13/07 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and dress of Facility Greene Fungal SNCS 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on mach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** KESPIRATORY /Medical Due to (or as a consequence of): Examiner SPSIS Sequentially list conditions, any to limit fait cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumence of Examine No the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit HMONIC Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signatine and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9TH 2007 30. Name end address of person who completed dause of death (Item 23a) (Type, Print) SAMMRITAN HOSPITAL BALTIMORE ABASSI 900 31. Date filed (Month, I 9000 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygier Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 11, 2007 Day **Physician** 11:30 AM Wayne L. Cosgrove /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 1801 Cape May Rd If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 XM 2□F 67 212-36-5519 Director October 23, 1939 Maryland Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits 10c. City. Town or Location 27 le marked other than "naturel", or Items 23a or 28a-f ehow treumatic event, the Medical Examinar must be notified at 1 XYes 2 □ No Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 Cape May Rd. 21221 Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Un Known 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Service Officer Public Police and Mental Hygie permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 le marked othe any liqury or other treumatic event, sone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elmer Cosgrove L1114 Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 son Wayne Cosgrove, Jr Baltimore, MD 2122 1801 Cape May Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Anatomy Gifts Registry september 11,2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hanover, MD *4 Monation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 17522 Connelley Drive Suite P. Hanover, MD 21076 23a. Part1. Enter the dise to, or complications that caused the death. Do not enter the mode of dying, such all cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Reument esophageri 5 months /Medical Due to (or as a consequence of): Examiner ~16 months Esophageal cancer Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a cons ence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Month 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an certificate 2 No 1 Yes 25. Was case referred to medical funeral director 26. Place of Death | Check only one examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Magner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending Injun 5 Pending 4 hours after death.

Funeral Director: After ely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a
To the Funeral C
completely filled i 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 11 2007 D 0058893 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battemore, MD 21224 4940 Eastern Ilene Browner Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State BARL. Registrar CEP 19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 0 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) r 7, 2007 **Physician** Catherine Dolores Cochran September 6:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 602 "C" Carrolwood Road Middle River Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 21/21/ Days 212-56-8628 Director 10/16/1948 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 "C" Carrolwood Road 21220 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 3 ☐ No Specify: Specify: White ð 3XXVidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Restaurant Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, tt once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Reinsfelder Dolores Kachelle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason W. Cochran (Son) 4719 Mawani Road, Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial, 2 Cremation 3 | Removal from State 4 Defonation 5 ☐ Other (Specify) Dulaney Valley Mem. 09/11/2007 Timonium, Maryland 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A 21. Signature of Funeral Ser 1407 Old Eastern Avenue, Essex, Maryland 21221 3a. Part1. Enter the disease, or shock, or heart failure. List complications to it caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to one of the one each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exam P.O. Box 68760, physician the burial Completed by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 Ho Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has birector, page 2 s autopsy performed? 1 Yes 2 No 2□ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 V atural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: / 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check of 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

2 2007

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DHMH 17 Rev 1/2001

em 23a) (Type Print

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death **Physician** Month eptember 2007 /Medical 4c. County of Death Examiner Baltimore (enter If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday) **Funeral** Months Days 237-72-4046 1**X**M 2□ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Ces 2 □ No Funeral Director MDtimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 LSA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Statu Black, White, etc. 1 Yes 2 □ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be ဥ KNOL Agness 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation injury or 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): MINUTES /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown END-STAGE RENAL DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has e 2 autopsy performed? 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No ۵ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Vithin 24 hours after dean.

To the Funeral Director: A 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

CONRAD MAY MD State Registrar

31. Date filed (Month, Day, Year)...

BALTIMORE VAMC 32. Egistrar's Signature SEP 1 2 2007

MRY MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(marks)

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09-02-2007

10 N. GREENE ST., BALTIMORE MD 21201

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	State of Maryland / Department	of H	ealth and M	ental Hv	giene?	107

		For State Registrar		ertificate of L			eg. No.	1 29118	
Physicia /Medic		1. Decedent's Name (First, Middle, Last) $Bruce$	Decke	r		2. Date of Deat Month Sept 5.	Day Ye	ar 8:30 P M	
Examin		4a. Facility Name (If not institution, give street and number) Futurecare Pineview		4b. City, Town, or CLint			4c. County of D	Death Ce George	
Funeral Director		141 44 8873 XX ^{M 2□F}	e (In yrs. last birthday 56 Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day Aug 2	4 ^{Year} , 1951	Birthplace (State or Foreign Country) ITginia	
Ba-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George		10d. Inside City Limits 1 ☐ Yes 2 ☐ No					
th with th		10e. Street and Number 9106 Pineview Lane	2	10f. Zip Code 20735			Og. Citizen of Wha United		
urs after deal ai', or items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Nivorced 12. Was Decedent Amed Forces? 1 Yes, Give	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2☐ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White	
be filed within 72 hours after death with the Maryland ital hygiene. Ind other than "natural", or items 23a or 28s-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or state)	(Giv		uring most of work	ing		ess/Industry taurant	
ed fa b	To Be C	17. Father's Name <i>(First, Middle, Last)</i> UNKNOWN			18. Mother's Name UNKN	e (First, Middle, I	Maiden Sumame)		
1 end 2 a Heelth ar em 27 is ther trau		19a. Informant's Name/Relationship (Type, Print) Paul Roger Smith (Bro	other) 62	position (Name of	ster Ro	ad, Ch		eld, Va ₂₃₈₃	
permit. Pages Depertment of important: if it any injury or o		1 Burial 2 Germation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Figure Service Censee	Lee Cr	ematory or other place ematory 22. Name and Addres	Sept 6, s of Facility Lee	2007 Funer	Clinton al Home	, MD ,Inc 6633 O	
8 8 1 2 8	-	23a Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	d the death. Do not e	lexandri				n, MD 2073 Approximate Interval Between	
Physician // Medical physician ond physician structure of physician and physician structure of the phy	edical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events a. Due to (or as Diable by Due to (or as Diable by Due to (or as Diable by Due to (or as Diable by Due to (or as Diable by Diable by Due to (or as Diable by Diable by Diable by Due to (or as Diable by Diable by Diable by Due to (or as Diable by Diable by Diable by Due to (or as Diable by Diabl	Stage Ren a consequence of): etes Mell a consequence of): etension a consequence of):		56				
	Physician/Med	230. Was decedent pregnant 1 Live birth	Sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					f delivery Day Year	
The faw requires that the death cert tte has been signed by the attending bage 2 should be detached for use a	þ	Part II. Other significant conditions contributing to death b		23e. Did tobacco use contribute to the cause of death					
	Completed					24a. Was a autop: perfor	sy prior deat	e autopsy findings available rocompletion of cause of th? Yes 2 \sum No	
Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner? 1 Yes	ent 2 ER/Outpatio	ent 3 DOA Othe	26. Place of Deat		ne) ence 6 □Other(Specify)	
ding After funer	ation: To	27. Manner of Death 1-D Natural 5 Pending 2 Accident investigation	ury 28b. Time	of 28c. Injury Work			ow injury occurred	арос пу)	
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To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	edicai (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To ti To ti comp	Ň	29b. Signature and title of certifier		29c. License D 5 1	number 520	d	29d. Date signed (A Sept 6	, 2007	
17		30. Name and address of person who completed cause of Bahram Pishdad, M.D.			e S.E.,	Suite	310, W	20032 ashington D	
Sta Registr			rar's Signature						
HMH 17 Rev 1/2	001	· ·	ORIG						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#12 perFH C871 9/12/07 WS State of Maryland Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death - 2007 Physician 2:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOME Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign
Country) **Funeral** 1**Z**M 2□F Months Min. Yrs. Director Maryland Usual Residence of Decedent a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director MD TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 Items 23a Examiner must Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes. Gi "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 🔏 No Specify: ģ 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within 72 Health and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Magonee. Elementary/Secondary (0-12) Gollege (1-4or 5+) lechnician 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Garrison Forest Marial 2 ☐ Cremation 3 Removal from State ON Owings Mills, MI 4 Donation 5 Other (Specify) emeder 21. Signature of Funeral Service Licensee bock 2d. Bal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final LREMIA DAYS **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner RENAL DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner RENAL CELL

Due to (or as a consequence of): Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown detached for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by HUPERTZNSION 2 No 1 🔲 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No RENAL TRANSPLANT or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) Other 20No 1 ☐ Yes Medical Certification: To o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D64395 SEPTEMBER 9. 2007 pleted cause of death (Item 23a) (Type, Print) 10 DANIEUE DUBERMAN, ND 6565 N CHAPLES ST, SMITE 216, BACTIMORE, MD 21 204 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 1:45am M September 8, Harry Michael Ford Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner **Baltimore** Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Min 1 XM 2 □ F \mathbb{C} Director 63 5**7**8-60-2283 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. XXYes 2 □ No Director Baltimore n/a 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21229 IISA 663 So. Wickham Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. African-Specify: American 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Naval Air Sysytems Command Elementary/Secondary (0-12) College (1-4or 5+) Weapons Specialist Dept. of Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Hawkins James Alexander Ford 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 663 So. Wickham Road, Baltimore, MD 21229 Janet Lee Ford/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Garrison Forest Veterans 19-13-07 Owings Mills, MD 22. Name and Address of Facility Wile F/ HP.A. of Baltimore County 21. Smature of Funeral Service License 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer Due to (*r as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-trar Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacoo use contribute to the cause of death? Be Completed by pe 1 Pres 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2010 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death.

uneral Director: A death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated nn M. Hoster, nd)29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 192 30. Name and address of person who completed cause of death (Item 23a) Type, Print 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Physician: The law requires that the death certificate be executed

Hospital or Attending

Division or Vital Records, P.O. Box 68760,

death with the Maryland

Ford, Harry Baltimore, Maryland 21215-0036

Physician /Medical Examiner The law requires that the death certificate be executed as the burial-transi

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attending physician

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Director: After that in by the funeral

Hospital or Attending

after

Vithin 24 hours area To the Funeral Dir

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Director

Funeral

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Completed

Be

death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumatic event, th. Medical Expone.

Baltimore, Maryland 21215-0036

Examiner Completed by Physician/Medical

Be

10

Certification:

Medical

State

Registrar

IF FEMALE 23b. Was decedent pregnant n the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

ACUTE RENAL FAILURE

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation

6 ☐ Could not be

determined

(Month, Day Year)

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

2 Accident

3 ☐ Suicide

4 ☐ Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

forman, medical intern Muhelle

BALTIMORE, MD 21225 ST

RES0001

29d. Date signed (Month, Day, Year) SEPT 06,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHELLE FORMAN 31. Date filed (Month, Day, Year)

SEP 1 2 2007



3001 SOUTH HANOVER

Carlo Comment

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Amend 24a, perverbal, 6871, 9/12/07 TCertificate of Death Reg. No. 2 0 0 7

2. Date of Death

September 11, 2007

06:00 A M

1. Decedent's Name (First, Middle, Last)

Joseph Calvin Gray, Jr.

Physician

/Medical

				ise Type or Pri			delible lnk. artment of H				_	ble.			
			For State Registrar			Cei	rtificate of	Death			Reg. N2 0 (7	291	83	
F	Physicia	an	1. Decedent's Name (First, Middle		u D					2. Date of De Month	er 10 2	Year			
	/Medic	al	Vera D. 4a. Facility Name (If not institution		h.D.		4b. City, Town, o	r Location o		eptemb	4c. County		6:40	P ™	
	Examin	er	Stella Maris 5. Social Security Number			ast birthday)	Timoniu If Under 1 Year	ım		8. Date of Birt	Balt	imor		or Foreian	
	Funeral Director		219-56-4693 Usual Residence of Decedent	1 □ M 2 欠 F	82	Yrs.	Months Days	Hours	Min.	(Month, Da March 2	, Year) 925	Ma	ryland		
	faryland show ed at	or	10a. State 10b. County Md. Balti			, Town or Lo Lmoniu									
	ith the N or 28a-1 se notifi	Director	10e. Street and Number			·	10f. Zip Code	21093			10g. Citizen of	What Cou USA	ntry?		
	eath w			ring Rd. 5-41		S 13			gin? (Spec	ify Ves or No	- 14. Rac		can Indian.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ※ Widowed 4 ☐ Divorced	Armed Forces? ried 1 ☐ Yes 2 ☑ If Yes, Give	?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐ No	an, Mexicar Specify:	i, Puerto R	lican, etc.)	Blac	ok, White, V∶ Whi	etc.		
15-0036	n 72 hou "natura edical E	Completed	(Specify only highe	nt's Education est grade completed)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	nation during mos	t of working	g	16b. Kind of B	usiness/Ir	thplace (State or Foreign and Y) and 10d. Inside City Limits 1		
2121	d withii giene. ar than the M	omo	Elementary/Secondary (0-12)	College (1-4or	5+)		lege Prof		<u>.</u>		Educa	ation		_	
Maryland	ild be file fental Hy rked othe lic event,	To Be C	17. Father's Name (First, Middle Richard J. Duy					18. Mothe	er's Name (rgare	(First, Middle, t Gert:	Maiden Surnar rude Wil	_{ne)} .kins	on		
lary	2 shou and N is mar		19a. Informant's Name/Relations				ng Address (Street						Code)		
و. ک	1 and Health em 27 em 27		Mrs. Alma Meagh	ner/ Sister	20b. P	lace of Dispo	Ainsley		Da Da		20c. Location		own, State		
Baltimore,	Pages ment of tant: If it jury or c		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify)		kwood	matorý or other plac Cemetery	1	9-14-1	07	Baltir	nore,	Md.		
Ball	permit Depart Import any In once.		21. Signature of Funeral Service	Licentigee		2	2. Name and Addre			eral H	ome, Ing	204			
8	1950		23a. Part . Enter the disea , o shock, or heart failure. Lis	or complications that cause tonly one cause on each I	d the death	n. Do not en	ter the mode of dyir	ng, such as	cardiac or	respiratory a	rrest,		Interval Be	tween	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. RECTAL	CANCE	ER							Onset and	Death	
	/Medical Examiner			Due to (or as	a consequ	uence of):									
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<u>,</u>	executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	uence of):									
9876	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical		d											
Box 6	th certifi ending r use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐Live birth			⊒Ectopic pregnanc	v				ite of deliv		Voor	
P.O. E	the dea y the att iched fo	nysici	in the past 12 months? 1 □ Yes 2 🙀 No 9 □ Unknown	4□Pregnant a 9□Unknown			Other (specify)				IVI	onth	Бау	Teal	
д <u>у</u> , г	ires that signed b I be deta	by	Part II. Other significant condit	ions contributing to death I	but not resu	ulting in the u	inderlying cause giv	en in Part I	l.	23e. Did t					
Records,	w requ	leted								24a. Was	an 24b.	Were aut	opsy findings	available	
al Re	: The lav cate has	Completed									psy ormed? 2 X No	prior to co death? 1 ☐ Yes		cause of	
Vita	rsician s certifi lirector	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 📉 No	al Hospital: 1 ☐ Inpati	ient 2 🗆	ER/Outpatie	nt 3□ DOA Oth	or:		(Check only one 5 □ Resi		ner (Snec	ifu) HOST	TCF	
n or	ding Physician: The After this certificate h. funeral director, page	on: To	27. Manner of Death 1 Natural 5 □ Pendi	28a. Date of Inj	ury	28b. Time of Injury					how injury occur		W HOSI	TOE	
Division or	Attendir er death. rector: A by the fu	icatic	2 ☐ Accident invest	ligation	iury - At ho	ome, farm, st	M 1 ☐ reet, factory, office	Yes 2□		8f Location (Street and Num	ber ar Rui	al Route Nu	mber.	
N N	lal or Atten s after death al Director: ed in by the	Certification:	4 ☐ Homicide determ	mined 206. Flace of III	tc. (Specify	y)				City or To					
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the but	edical (ing Physician: To the best I Examiner: On the basis and manner s	of examina									(s)	
	To th within To th comp	Me	29b. Signature and title of certifi	er			29c. Licens	se number			29d. Date signe	ed (Month	, Day, Year)		
				/				143	121	S	9	/11/	07		
	5		30. Name and address of person DR. TARIO MAH					ттмом	TIM	MD 210	193				
<u>la</u>	Sta		31. Date filed (Month, Day, Year	r) 32 Regist	rar's Signa			THON	z.UI13	111/210	1.1.1				
	Regist	ar	SEP 1 2	LUUI SILOMA	and Si	SID									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Month Hayes 9 2:45p Sandra 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Towson Gilchrist Hospice Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 💢 F Md. 12-23-1958 48 216-76-9415 al Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2□No Baltimore NA 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA 21218 2011 Robb Street Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify: Black 1 ☐ Yes 2 🎇 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) J.H.H. University Admin. Ass't 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mae Parker Willie Hayes Samuel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2011 Robb Street, Baltimore, Md. Daughter Pamela Jones 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9-14-07 Randallstown, Md. King Mem. Pk. of Funeral Service License 22. Name and Address of Facility 21. Signatur March F.H. East 21202 1101 E. North Ave., Baltimore, Md. Part1 Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedia Cause (Final sease r condition NON-SMALL Due to (or as a consequence of): Sequentially list conditions

Physician /Medical Examiner

Physician

/Medical

10a. State

Md.

Examiner

Funeral

Director

28a-f show

Directo

Funeral

à

Completed

Be

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

es 1 and 2 should be filed w of Health and Mental Hygie fitem 27 is marked other ti

permit. Pages Department of Important: If its any injury or o

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner attending physician and for use as the burial-trans signed by the a has within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

10

Division or Vital Records, P.O. Box 68760,

if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	
IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 10 10 10 10 10 10 10 10 10 10 10 10 1	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 ☐ Yes No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (C	Check only one)
examiner? 1 Yes 2	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 ☐ Residence 6 Mother (Specify) HOSPICE
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	n (<i>Month, Ďaý Year)</i> Injury Work? n M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
3 Suicide 6 Could not t 4 Homicide determined		Location (Street and Number or Rural Route Number, City or Town, State)
	nysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	

29c. License number

D64395

6565 N CHARLES ST. SUITE 216 BALTIMORE, MD 21204

29d. Date signed (Month, Day, Year)

SEPTEMBER 10, 2007

DHMH 17 Rev 1/2001

4

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

DANIEUE DOBERMAN, MD

30. Name and address of person who complete use of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 10,2007 **Physician** Patrick Allen Hall Sr. 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2507 Fox Rd. Harford Fallston If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days 1 🔀 M 2 🗆 F 215 38 9023 Director Aug.17,1937 Minnesota Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2X No Maryland Harford Fallston Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 2507 Fox Rd. 21047 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1⊠Yes 2□No If Yes, Give 1954/62 Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wire filed with and Mental Hygier tem 27 is marked other th Maintenance Technician Soap Mfq. permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Frederick Hall Rosemary McPherson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Treva Faye Hall (Wife) 2507 Fox Rd. Fallston, Maryland 21047 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 9/13/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Licensee Zicharl 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or control that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS Wins, Arry DISGASE Physician Chronic OBSHULTUE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of) ng physician a Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 █ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled in

P.O. Records. Division or Vital

> State Registrar

10+1

29a. Certifier

29b. Signature and title

31. Date filed (Month, Day, Year)

SEP

of certified

Jason Birnbaum

Medical

manner stated

M. D. 0 in 32 Aegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

602 South Atwood Road

10056296

29d. Date signed (Month, Day, Year)

Suite 206

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Carolyn Edith Richardson Hardin Sept. 10, 3:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3412 Mayfield Avenue Windscr Mill Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay. Y 07-30-1955 **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months Days Hours 214-62-9112 Director MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director MDBaltimore Windsor Mill 1 ☐ Yes 🏖 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3412 Mayfield Avenue 21244 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Be Completed by SpecifAfrican-American 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fingerprint Technician State Of Maryland 5+ 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file treent of Health and Mental H tant: If item 27 Is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Charles E. Richardson Ida Mae Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hardin/Husband 3412 Mayfield Avenue, Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 9-15-07 Baltimore, MD 21. Signature of Lunoral S 22. Name and Address of Facility Wylie F/ H P.A. of Baltimore County 9200 Liberty Rd., Randallstown, MD 21133 Enter the discusse, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (y as a consequence of): /Medical resulting in death) Examiner oue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical as the 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Drauffrenny 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed s cer ificate has t lirec or, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2⊠No performed: autonsv To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

821 N.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2. Registrar's Signature

POTOTSKY

KONALD S.

31. Date filed (Month, Day, Year)

1)13004

Evrow S. # 202 BALTIMIRE, MO21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fly 98/1 9-17-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept9, **Physician** 11:20 PM 2007 Joseph Francis Humphreys /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3256 Guilford Drive Waldorf Charles If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth 1952 **Funeral** XX M 2 F Director 279 64 3901 55 July 29, 2952 Washington DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Itams 23a or 28e-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2/No Maryland Charles County Directo Waldorf the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3256 Guilford Drive 20602 Unitd States Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married A Married Baltimore, Maryland 21215-0036 1 ☐ Yes X X No Specity: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. If Item 27 is marked other then Sales Manager Sales 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be John J. Humphreys Mary J. Monaco ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Humphreys (Wife) 3256 Guilford Drive, Waldof, MD 20602 20b. Place of Disposition (Name of cometery, crematory or other place) Sept 14, Date 2007 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State = 5 Depertment of Important: If eny injury or once. Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 22. Name and Address of Facility Eee Funeral Home, Inc 6633 01d 21. Signature Licensee Alexandria Ferry Road, Clinton, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIABSFS **Physician** MANY YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION 78AL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner ending physicien and use as the burial-transit The law requires that the death certificate be executed MORBIN SAM Due to (or as a consequence of Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ PERI DARRAL VASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed PER CIPIDIMIS 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No မ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Leath 28b. Time of Certification; 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending after death.

Director: Aft 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funerel Direc 4 Homicide to Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21173 60 res () 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRAN. P. SHARATA WASHINGTOW AD 3460 010 WALDORF 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State 1 2 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9 Michael tolman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Small bultmore Trauna If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F Months Days Hours Director 214-56-1311 54 24,1952 Pennsylvania Nov. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ntt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f shov edical Examlner must be notified at 1 ☐ Yes 2X No Director Baltimore Nottingham Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 21236 8508 Hanf Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No 1971 –
If Yes, Give
Year or Dates: 1973 1 ☐ Never Married 2 🛱 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify Completed by 3 Widowed 4 Divorced 1973 White item 27 Is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Loan Officer Mortgage Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Holman Elaine Weiss ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8508 Hanf Avenue, Nottingham, Maryland 21236 Donna M. Holman (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of It
Important: If ite
any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 09/12/2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signarure of Funeral Service ticensee Bum D 9705 Belair Road, Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical o (or as a consequence of) Examiner Neuroturna Fasci Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physiclan; The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 ☐ Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 √Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 1☐ Yes 219 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 ျှ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No s after death. death. 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide within 24 hours aff

To the Funeral Di

completely filled in Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

tomber 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

Lo 22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007 2

32. Registrar's Signature

the

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Itmore.

			For	State	of Maryla			lealth and M	lental Hy	giene		•	0.0		
			State Registrar			Ce	rtificate of	Death		Reg. No	007	291	89		
П	Physicia	an	Decedent's Name (First, Midd	Date of De Month	Day	Year	3. Time of D	M							
×2.	/Medic	al	4a. Facility Name (If not institution		MARGAR			r Location of Death	SEPT.	10, 4c, Co	2007 unty of Death	2:07	Р ""		
	Examin	er	CARROLL HOS			SE.		INSTER			RROLL				
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		place (State or	Foreign		
b	Director		219-20-0320	1 □ M 2 X F	8	1 Yrs.	Wortuis Days	Tiodis Will.	4/28/	1926		IÍGAN			
	w		Usual Residence of Decedent 10a, State 10b, County	,	10c. C	ity, Town or Lo	ocation					10d. Inside City	y Limits		
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The first of the f											- Cadal				
Mar	d2sh thanc 7 is n traun		19a. Informant's Name/Relation	, , , , ,	iCumed		•	E DR., R		-			;		
	1 and Healt tem 2		ANNA HOCK 20a. Method of Disposition	- DAG	JGHTER 20b.	Place of Dispo	osition (Name of	i	Date		tion - City or T				
<u>o</u> E	Pages nent of h ant: If ite ary or o		1 X Burial 2 □ Cremation 4 Donation 5 □ Other (m State	-	matory or other pla J_MEM_G2	RDENS 9	/13/07	FINE	KSBURG	. MD			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.			e Lansee	11 / 11	2	2. Name and Addre	ess of Facility ${ m FL}$	ETCHER	FUNI	ERAL H	IOME,			
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		9	shock, or heart failure. Lis	it only one cause o	n each line.							Approximate Interval Bety Onset and D	veen Death		
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8760,	cate t physic	dical		d					-						
w.	The law requires that the death certifitate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome pf preg					230	d. Date of deliv	ery			
Box	death e atter	iciar	in the past 12 months?	4□Pre	e birth 2□Fe egnant at time o		□Ectopic pregnand □ Other <i>(specify)</i> _	У			Month	Day Y	rear .		
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Zit.	Physician: r this certific ral director,	Be	25. Was case referred to medic examiner?	Hospital:			-t all pos Ot	26. Place of Death				" HOCD			
ō	Phys	<u>۲</u>	1 Yes 2 No 27. Manner of Death	28a. Da	☐ Inpatient 2 ate of Injury	28b. Time		4 ☐ Nursing He	ome 5 ☐ Res 28d. Describe			IIV) HUSP	TCE_		
ion	Attending ir death. ector: Afte by the fune	ation	1 ☑ Natural 5 ☐ Pend 2 ☐ Accident inves	ing (<i>N</i> tigation	fonth, Day Year)	Injury		ork?]Yes 2 □ No							
Division or Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minad Zoe. FR	ace of injury - At uilding, etc. (Spe	home, farm, st	treet, factory, office		28f. Location City or To	(Street and I own, State)	Number or Ru	ral Route Num	ber,		
	pital ours ai		29a. Certifier 1 Certify	ing Physician: To	the best of my k	nowledge, dea	th occurred at the	time, date and place	, and due to the	e cause(s) a	nd manner as	stated.			
	the Hospital hin 24 hours a the Funeral upletely filled	Medical	(Check only 2 Medica one)	al Examiner: On th	e basis of exami nanner stated.	nation and/or i	nvestigation, in my	opinion, death occu	rred at the time	, date and p	lace, and due	to the cause(s	;)		
	To th within To th	Me	29b. Signature and title of certif	ier 110				se number		29d. Date	signed (Month		2 2		
			Mach	MO			D	52035		Sep.	tember	11	2007		
•	7		30. Name and address of person		ause of death (It	em 23a) (Type	Print)	52035 Wertmer	when	M	211	57			
	Sta	ate	31. Date filed (Month, Day, Yea		2. Registrar's Sig	nature			*						
	Regist		SED 1	2 2007	Barrie	K	Sirely)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23 anary Rent / 496p at 871 n Poil 4 and 1 Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 1426 MORRO HAWKINS AUGUST 23 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTMOLE VUIVERS MY OF MACHILAND MEDICAL CENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🔏 F 1 and Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 **2** es 2 □ No Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2☐No Specify: 3 ☐ Widowed 4 ☐ Divorced 1ac Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Collage (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be nomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) illiam How 2405 Hermosa Burial 2 Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rattimore, MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End Stage Renal Disease Due to (or as a consequence of): Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Significant Sacral Decubitus Ulcer Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?
Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 20 No Hospital: Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 ₩Natural 5 ☐ Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Physician /Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, signed by the a page 2 s Hospital or Attending Physician: after death. the 24 hours a within 24

Funeral

Director

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'natural", er than "nature the Medical E

7 Is marked other traumatic event,

Department of Health Important: If item 27 any injury or other tr once.

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with Inent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar

Be

Certification: To

Medical

ADLEN 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

South

BAUTHORE

18264

29c. License number

212-07

29d. Date signed (Month. Dav. Year) AUGUST 2007

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

6 ENENE

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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07-07004 Dar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

irryl Harcum	State of Maryland / Departme 1-For State	ent of Health and Mental Hy ate of Death	ygierie 20	07 2919						
Physician/ edical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) Darryl Harcum		2. Date of Death Month Day Year September 9, 2007	3. Time of Death 1145 hrs						
edical Examiner	4a. Facility Name (if not institution, give street and number) University Hospital Shock Trauma	4b. City, Town, or Location of Death Baltimore		ath						
Funeral Director	5. Social Security Number 213-84-2915 6. Sex 7. Age (In yrs. last birth	8. Date of Birth(MM/DD/YYYY) g. For Dec. 23, 1961	Birthplace (State or eign Country) MD							
/land -f show any once. :tor	Usual Residence of Decedent 10a. State	Baltimore 10f. Zip Code	10g. Citizen of What C	10d. Inside City Limits 1 X Yes 2 No						
a or 28a-f shotified at one	2520 Lauretta Avenue	21223	US	SA						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fitten 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced of Pages 1 Armed Forces? 1 Yes 2 X No If Capacity Yes 2 X Yes 2 X No If Capacity Yes 2 X Yes	 13. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No specify: 	Rican, etc.) White, etc.	nerican Indian, Black,						
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner Completed by 1		Decedent's Usual Occupation (Give kind of luring most of working life. DO NOT use reti		ss/industry						
215-00 be filed wit ntal Hygien riked other ent, the MB Be Con	17. Father's Name (First, Middle, Last) Leroy Harcum		e (First, Middle, Maiden Surname) Mary E. Peters							
2121 rould be fi and Mental I is marked tic event,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	. Mailing Address (Street and Number or	Rural Route Number, City or Town, St	ate, Zip Code)						
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it. Pag ir. Pag irtment ortant:	4 Donation 5 Other Specify: 21. Signature of Funeral Service-Licensee		4/2007 Baltimore,							
Ba perm Depa Impo	June de Jones	, w	Wilie Funeral Home, P. Baltimore, Maryland							
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause of weach line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):	t enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death						
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executed an and al - transit	d. UNPENDED AMENDED									
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directors. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Esterical Certification:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1									
res that the signed by the detached	•	g in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3	e to the cause of death? Probably 4 Unknown						
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Division o spital or Attending rours after death. neral Director: After filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Single Family	arm, street, factory, office building, etc.	28f. Location (Street and Number o or Town, State) 2520 Lauretta Avenue, Baltimor							
Division To the Hospital or Attend within 24 hours after death withe Funeral Director: completely filled in by the		ath occurred at the time, date and place, an nvestigation, in my opinion, death occurred	d due to the cause(s) and manner as at the time, date and place, and due to	stated. the cause(s)						
Z × Z o	Ill by MA	29c. License number O.C.M.E.	29d. Date signed September 10							
2	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD	D 21201							
Stat	31. Date filed (Month, Day, Year) 32. Registrar's Signature									
DHMH 17 Rev 1/2001		And And And And And And And And And And								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 9 **Physician** onald Lamont /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rehabilitation Extended Car BALL: MOR 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MARYLAND **Funeral** 6. Sex Days 1XXM 2□ F Months Hours Min. Director 219-50-1017 FEB. 12 1949 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 XYes 2 No Director MARYLAND BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö "natural", or items 23a 1843 W MULBERRY STREET 21223 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2\(\times\)No by Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 Is marked other thar other traumatic event, the M 10th grade ENVIRONMENTAL AIDE BALTIMORE CITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ JOSEPHINE MOORE CHARLES JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1843 W. Mulberry St., Baltimore, Maryland 21223 Helen Johnson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 1 ☐ Buria! 2> ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Other (Specify) METRO CREMATORY 09-12-07 BALTIMORE, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Signature of Funeral Service Lice 1206 W NORTH AVENUE Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Zist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner hronic ancv Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 **⊴**Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has e 2 certificate has rector, page 2 autopsy 2 2 No 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manny of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) vivatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2007 29194

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Physicia Examir	11/	Albert Jon						,	Month September				
		4a. Facility Name (if not institutio	n, give street and num	ber)	4	b. City, Town,		Death			Death		
		University of MD Hosp			1	Baltimore					(0)		
Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. last birt	hday)	If Under 1 Y		1 44.		IF:	oreign		
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Maryland 28a-f show any d at once.	홠	10e. Street and Number				10f. Zip Code	Э		10	g. Citizen of What	Country?		
h the Maryland 3a or 28a-f sho	Director		ilton Au	oniio		2120	15			USA	3. Time of Death 0400 hrs 10. County of Death N/A WDD/YYYY 9. Birthplace (State or Foreign Country) Virginia 10. Inside City Limits 1 X Yes 2 No No iditizen of What Country? SA 14. Race - American Indian, Black, White, etc. Specify: Black 0. Kind of Business/Industry ublic Parking Loten Surname) 10. City or Town, State, Zip Code) timore, Md. 21205 10. Location - City or Town, State Catonsville, Md. Home, PA More, Md. 21217 Shock, or heart Approximate interval Between Onset and Death 23d. Date of delivery Month Day Year 24b. Were autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 27 No 1 Yes 2 No 28c. Catons Ville, Md. 29 No 29 No 29 No 20 No 20 No 20 No 20 No 20 No 21 No 22 No 24b. Were autopsy findings available prior to completion of cause of death? 29 No 1 Yes 2 No 20 No 21 No 22 No 23d. Date of delivery No 1 Yes 2 No		
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r dea or it	교		1 Yes vorced If Yes, Give Year	2 X No	1	Yes 2 X	No specify:			Specify: I	3lack		
safte	<u>۾</u>	15. Decedent's Education (Spe	Lor Dates:		Deceder	t's Usuat Occi	pation (Give k	kind of wo	ork done	16b. Kind of Busin	ness/Industry		
72 hours n "natur	Ee G	Elementary/Secondary (0-12)			during m	ost of working	life. DO NOT	use retire			, made		
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5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	Completed	17. Father's Name (First, Middle	e. Last)			0	18.Mother	s Name	(First, Middle, I	Maiden Surname)			
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and 2 earth earth fraur	- 11	20a. Method of Disposition		20b. Place	of Dispo	sition (Name o	f cemetery,		Date	20c. Location - 0	City or Town, State		
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Baltimore, permit, Pages I an Department of Hea Important: If ite injury or other tr.		4 Donation 5 Other 3	Specify:	Metr	*O U	remato	OT y tress of Facility	v / O	72001	1 Hama	DA		
alt rmit epart ipor jury		21. ature of Funeral Service	e Licen e	h() 8 110	L É	step 1	3rothe	rs	Funera	al Home	, PA Md. 21217		
III 8 9 7 1 1		2 a. Part I. Enter the disea e. o	Hill	COLOR D	et enter	the mode of the	ing. such as c	ardiác o	r respiratory ari	est, shock, or hear	rt Approximate Interva		
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Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Fineral Director: After this certificate has been signed by the atte	oleiy		g Physician: To the b	est of my knowledge,	death oc	curred at the t	me, date and pointion, death	occurred	at the time, da	te and place, and	due to the cause(s)		
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W. Plan		30. Name and address of per	rson the completed ca	aus of death (Item 23	3a)								
100		Jack Titus MD.	Deputy Chief Med	dical Examiner	111 F	enn Stree	t, Baltimore	e, MD 2	21201				
	Stat			Registrar's Signature	- 6								
	Stai istra	6.1	2 2007	Carren S.	A. C.	and I							

07-06959 Yolanda Jubilee Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2007 29195 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day September 7, 2007 1755 hrs Medical Examiner YOLANDA JUBILEE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** N/A 501 E. Preston Street, Apt. 602 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Months Days Hours Min Director 45 217 80 7256 1 M 2X F Yrs NOV.8,1961 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 10a. State 1 X Yes 2 No BALTIMORE MD. N/A notified at once, Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 21202 501 E. Preston St. 23а 14. Race - American Indian, Black, with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. must be Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 1 Never Married Married Yes Yes 2X No specify: f Yes. Give Year BLACK Baltimore, MD 21215-0036
permit, Pages I and 2 shouldbe filed within 72 hours after
Department of Health and Mental Hygeria.
Department of Health and Mental Hygeria in Important: I if item 27 is marked other than "matural", injury or other trainmatic event, the Medical Examinez. 4 X Divorced ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) NONE 10TH NONE 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VIRGINIA L. SWANN Be ALBERT SWANN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 201 1100 PENNSYLVANIA AVE.APT.308 balto, Ma VIRGINIA L. SWANN(mother) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State SEPT.14,2007BALTO,MD. OAKLAWN CEM Onation 5 Other Specify: 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME nature of Funeral Service License Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 1213 proximate Interval **Physician** Between Onset and failure. List only one cause on each line Death /Medical a. Complications of Chronic Alcoholism Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 8Wi and Physician/Medical 20b per fh g871 9-12-07 vt AMENDED the attending physician ed for use as the burial UNPENDED The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 V Unknown 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 ✔ No 3 Probably 4 Unknown Ś σ. Completed 24b. Were autopsy findings available Records, 24a. Was an prior to completion of cause of autopsy has performed? death? ✓ Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical **Division of Vital** Be Other₄ Residence 6 Other: Scene Hospital: 1 Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 🗹 Natural Yes 2 No Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 8, 2007 O.C.M.E. & DOME the completed cause of death (Item 23a) 30. Name and ag 111 Penn Street, Baltimore, MD 21201 ripple MD. Deputy Chief Medical Examiner Mary G. 31. Date filed (Month Day, Year)

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Jeffrey Obrian 6:20 PM Jones 08/ 2007 09 /Medical 4c. County of Death me (If not institution, give street and number City, Town, or Location of Death Examiner Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Min 1**X**M 2□F Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1. Yes 2 No **Funeral Director** t more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) ews NICIAN permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, <u>tt</u> 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother Alamedo Balto.ND arbara 20b. Place of Disposition (Name of Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying-shock, or heart failure. List only one cause on each line. uch as cardiac or respiratory arrest. immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Medical

Hospital or Attending Physician; The law requires that the death certificate be executed To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dii

29a, Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD AM 2556996M 255 9/8/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. Villamayor April

State Registrar 31. Date filed (Month, Day, Year) SEP 12 2007 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 9 King 12 08 M **Physician** Nannie 2057 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 🙀 F N.C. 10-5-27 79 Director 238-36-8235 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County a or 28a-f show be notified at 1 XYes 2 No Baltimore NA Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21217 USA 715 Lennox Street "natural", or Items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Baltimore, Maryland 21215-0036 Specify. Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) American Tobacco Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker 5th grade 17. Father's Name (First, Middle, Last) is marked other 18. Mother's Name (First, Middle, Maiden Surname) Be Sturdivant and Mental Frank Boyd ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is nany Injury or 4828 Bowland Avenue, Baltimore, Md. Catonia King Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition . ↑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (*Specify*) 9-12-07 Lansdowne, Md. Mt. Zion Cem. 22. Name and Address of Facility March F.H. East 21. Sign turn of Funeral Service Licensee 21202 1101 E. North Ave., Baltimore, Md. Firt1. Enter the disease, or complications that ceused the dayn. Do not enter the mode of dying, such as cardiac or respiratory arrest, hoc or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Unknow Coronary Physician disease of condition resulting n death) /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death After Injury 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No r death. 2 Accident after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af.

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Hospital 29a. Certifier Medical 29b. Signature and title of certifie 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) On ion P Matthe: Basn 1).0 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Year sept. 11, **Physician** Ann T. Kingston 1:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Mandarin Hospice Anne Arundel Harwood 5. Social Security Number 8. Date of Birth (Month, Day, Year) 02/08/1928 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday 6. Sex **Funeral** Hours 1 ☐ M 2 💢 F 79 083-22-7311 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X es 2 No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 34 Lafayette Avenue United States Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □ Yes 2 🔀 No Specify: 3 XWidowed 4 ☐ Divorced ear or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretarial Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret O'Connell Thomas McGoey ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori Lyon, Daughter 34 Lafayette Avenue, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State Blue Mt. Cemetery 9/17/07 Saugerties, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer 22. Name and Address of Facility Servi M01113 Seamon-Wilsey Funeral Home 45 John Street, Saugerties, NY 12477 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se wentially list conditions Se mentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this s after death. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10,

State Registrar SEP 1 2 2007

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Resistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 10, 2007 **Physician** 9:14 AM September /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Harford 601 Cornell Street Aberdeen. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**1** M 2□ F **Funeral** Months Days Hours 212-46-7429 **Director** Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Director Harford Aberdeen 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ural", or Items 23a or 3 USA 601 Cornell Street 21001 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Delivery Courier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Carroll Keller Margorie Ann Brandenburg 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Dennison/Daughter 285 Maple Wreath Court, Abingdon, MD 20b. Place of Disposition (Name of cemetery, crematory or other particles Corporation Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/11/07 Towson, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 15 CHEMIC HEHRT DISENSE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DIMBETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 5 Other (specify) hed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 director, page 2 should be HYPERTENSION 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1∐ Yes 2 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1. Naturai 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Gretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 208096 drew Nowalconse. MD SEPTEMBER 10, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FULFORD AVE. BOLAR, MO 2014 NOWAKONSKI INDREW 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 2007

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Registrar

Examine attending physician and for use as the burial-trar

Physician/Medical

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Completed

Be (

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Certification:

Medical

certificate has

this

24 hours after death e Funeral Director:

within 2.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

Due to (or as a consequence of):

3 Ectopic pregnancy 5 ☐ Other (specify)

9 Unknown

28b. Time of

23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably

Month

23d. Date of delivery

Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

24a. Was an nerform

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

25. Was case referred to medical examiner? Hospital: 20 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

Uns, or

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

St

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier

1 Natural

Accident

3 Suicide

4 ☐ Homicide

29b. Signature and title of certifier

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltmore MD 21204

State Registrar

nav 185 2. Registrar's Signature 31. Date filed (Month, Day, SEP 1 2 2007

OBH ST.

Division or Vital Records, P.O. Box 68760;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,7$ Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jr. Charles Lambert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death **Examiner** uare If Unde Birthplace (State or Foreign Country)
 Maryland Date of Birth (Month, Day, Social Security Number Age (In yrs. last birthday If Under 1 Year **Funeral** 63 December 8,1943 218-42-9707 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 XNo Directo Baltimore Dundalk Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7411 Alvah Avenue Apt J. 21222 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: þ White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sam's Club 12 years 2 years Sales Associate ryland/21 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles R. Lambert Sr. Helen Hutton ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7535 Westfield Road, Dundalk, Maryland Mary Lambert ex-wife timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11, 2007 Dundalk, Maryland 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Approximate Interval Between Onset and Death 23a. Pakt Pinter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed the burial-tra Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 **X**No certificate has page 2 1∐ Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Attending 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident the | Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō within 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 🕮 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number tle of certifier 29d. Date signed (Month, Day, Year) 29b. Signature a 0 0002217 trees of person who completed cause of death (Item 23a) (Type, Print) 30. Name a sebastian Franklin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** CHARLES WILLIAM LOWERY SR. /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, Examiner 'esedale Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Hours Min 1**X**XM 2□ F 63 MAY 15 1944 MARYLAND Director 213-46-1976 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Important: If Item 27 is marked other than "inatural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director HARFORD CO **ABERDEEN** MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 118 GRANT STREET 21001 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2√CtNo Specify Specify:BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) timore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRANSPORTATION 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BESSIE LOWERY JOHN LOWERY ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Aberdeen, Maryland 21001 Elenora L. Lowery/Wife 118 Grant St., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 09-14-07 ABERDEEN, MARYLAND 4 □ Donation 5 □ Other (Specify) HARFORD MEMORIAL 21. Signature of Funeral Service Liens 22. Name and Address of Facility WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. S PHILADELPHIA BLVD., ABERDEEN, Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. mmediate Cause (Final disease or condition resulting in death) rection Welks Physician /Medical Due to (or as a consequence of): Examiner empyema Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner piration Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by disease seizure disorder 1 ☐ Yes 2 □ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe 2♥ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes Certification: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Marner of Death 28c. Injury at Work? 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in

DHMH 17 Rev 1/2001

completely

Medical

State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month Day,

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Year)

SEP

MD

32. Registrar's Signature

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Richard William Luckan 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 216-42-0316 62 April 14, **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2☑ No Funeral Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 704 Millwood Drive 21047 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Types 2 No
If Yes, Give
Year or Dates: Vietnam 1 Never Married 2 Married |8|ロナ at し こうだい altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banker/Stockbroker 5+ Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be f Mental h and Menta William Luckan ၉ Ann Virginia Archer Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Mrs. Susan <u>K. Luckan (Spouse</u>) 704 Millwood Drive Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of I Important: If It any Injury or o once. 1

Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Goins. 4 ☐ Donation 5 ☐ Other (Specify) 9/14/2007 Timonium Maryland 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Towson, Md. 21204 Section Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disconstruction of the shock, or heart fall or e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** lanoma disease or condition resulting in death) 6 months /Medical Due to (or as a consequence of): Examiner xuural effusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence/of) Examiner The law requires that the death certificate be executed that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) signed by the 9 Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MIII Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy perform spital or Attending Physician: Ti hours after death. uneral Director: After this certificate y filled in by the funeral director, pa 1□ Yes 2□ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No npatient ျ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral D 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0065827 2007

7587 7876 M

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

M.D. 500 upper Chesapoake Dr. Bel Air, MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

32.

Ries

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician Year 3:22 PM 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and n Examiner more 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 KF 6 Yrs. Director Mainia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No **Funeral Director** timore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industr (Give kind of work done during most of working life_DO NOT use retired) Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. e, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Augustu.
20a. Method of Disposition 110 . 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** hul. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9∏1Jnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 ☐ Probably 4 Onknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy
performed?

1 Yes 2 No 25. Was case referred to medica examiner? director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient Date of Injury (Month, Day Year) 27. Manne eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Injury 1 atural 5 Pending investigation n 24 hours after death.

ne Funeral Director; Af
bletely filled in by the fur 1 🗌 Yes 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier To the Hosp within 24 hor To the Fune completely fi and manner stated. 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of persor St #136 31. Date filed (Month, Day, 32 egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary	land / Depa/ <i>Cer</i>	rtment of F tificate of	lealth and M <i>Death</i>	1ental Hygi ®	ene g. No 200	7 29205
f	Physicia		Decedent's Name (First, Middle, Las MARY FRAM	n NCES BROWN I				2. Date of Death	Day 7, 200	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o Baltimo	r Location of Death	<u>.</u>	4c. County of De	
	Funeral Director		6 Social Security Number 6 Se		n yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 27,		Birthplace (State or Foreign Country) ryland
	aryland show d at	_	Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No
	r 28a-f notifie	Funeral Director	Maryland N/A 10e. Street and Number		Baltimo	10f. Zip Code		10	g. Citizen of What	Country?
	ath with	ralD	726 Highwood Dri				212		USA	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of ⊩ f Yes, specify Cub: 1 ☐ Yes 2M️No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Hace - A Black, W Specify:	merican Indian, Thite, etc. White
21215-0036		Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give life, L	dent's Usual Occup kind of work done DO NOT use retired amist Ass	during most of work	ting	16b. Kind of Busine Pharmacy	
d 21	filed w Hygiei other ti	O e	11 17. Father's Name (<i>First, Middle, Last</i>)		THAL	THE ASS	18. Mother's Name	e (First, Middle, N		
Maryland	ould be i Mental larked of	To Be	Harry Martin Bro	own			Frances	s Mans	sfield	
/ar	2 short and h	•	19a. Informant's Name/Relationship (7 Mary Patricia Hern				and Number or Rui		-	
	1 and Health tem 27 other to		20a. Method of Disposition		20b. Place of Dispo	sition (Name of			, Mary Land 20c. Location - City	
altimore,	Page nent o unt: If ury or		1 Durial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Sign 1 re of Fine, a Selvit Licen)	St. Mary'		etery 9/1			, Maryland
Ba	permit. Departr Imports any Inju		Martin D. Laws	son			iedefeld Road, Bal			
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition				ng, such as cardiac			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c		hrive				1 74
J	uted :	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a c						
8760,	ficate be executed g physician and ss the burial-transit	dical Exa	resulting in death) Last	Due to (or as a c	onsequence of):	-				
9	ertifica ling phi e as th	Medi	IF FEMALE:							
Division or Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filledlin by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
rds, P	quires that in signed bruid be deta	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	nderlying cause giv	ven in Part I.			e to the cause of death?] Probably 4 □ Unknown
l Reco	238	Completed						24a. Was ar autops perform 1 Yes 2	ned? deat	
Vita	siclan: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	0.5550	- all poal Oth	or.	th (Check only on		craughter's
10	g Physicar this leral di	n: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	28b. Time o				ence 6. AOther (Sow injury occurred	specify) your clare
sior	terding F eah. or: After the funera	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1		M 1	Yes 2 □ No			
Ž	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filledlin by the funeral director, page	Certification:	4 Homicide determined	28e. Place of injury building, etc. (- At home, farm, str (Specify)	reet, factory, office		28f. Location (St. City or Town		r Rural Route Number,
	Hospi 24 hour Funer etely fill	Medical		ysician: To the best of r niner: On the basis of ex and manner state	xamination and/or in					
)	To the within To the comple	Me	29b. Signature and title of certifier Mih - Orw			29c. Licens	0 3 1 8 b	.	9d. Date signed (M	
	le		30. Name and address of person who			Print)		wson	maz	
3	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's		- K Laz K	10	w yor		
	Regist	rar	SEP 1 2 200	07	15 1900	and a		-,		

07-06903

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sharlene Lee State of Maryland / Department of Health and Mental Hygiene 2007 29206 Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day September 5, 2007 Charlene Tee 0721 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Bon Secours Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) 218-96-8353 Months Davs Hours Director 2 X F 41 M June 28, 1966 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County MD Baltimore 1 X Yes 2 No 28a-f show death with the Maryland Director 10e: Street and Number 10f. Zip Code 10g. Citizen of What Country? 3007 Erdman Avenue 21213 TISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes'or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes African American 1 Yes 2 X No specify: Yes. Give Yea hours after Widowed Divorced "natural". ≦. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 72 F permit: Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Imporfant: If item 27 is marked other than the Medical MD 21215-0036 12 cosmetologist self-employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) matic event, Preston Lee Be Elizabeth Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 19a. Informant's Name/Relationship (Type, Print) Victoria Queen / Sister 3007 Erdman Avenue; Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date Baltimore. crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mount Zion Cemetery 09/13/2007 Baltimore, Maryland Donation 5 Other Specify: 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part I. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Pneumonia complicated by narcotic intoxication and cocaine use =xaminer Immediate Cause (Final disease_ or condition resulting in death) Due to (or as a consequence of): Sequentially list-conditions, if any, leading to immediate. Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed en signed by the attending physician and ald be detached for use as the burial - transi Physician/Medical XUNPENDED Records, P.O. Box 68760, 23c. If ves. outcome of pregnance 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Live birth Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? ✓ Yes Yes 2 the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Inpatient 2 ER/Outpatient 3 V DOA Nursing Home 5 After this 1 V Yes No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification:

Division of Vital

28a. Date of Injury (Month, Day, Year) Natural Yes 2 X No 5 unk Pending Fnd 9/5/2007 Fnd 6:45 am Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide or Town, State)
2231 Christian St. Baltimore. MD (Specify) found at home

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

September 6, 2007

Downa Nu Dincenti, M.D. 30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License numbe

O.C.M.E

31. Date filed (Month, Day, Year) 200

Homicid 29a. Certifier (Check only

29b. Signature and title of certifier

Donna M. Vincenti, MD

ORIGINAL

the Funeral Director: mpletely filled in by the

2

Medical

State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 9 Markell 2007 11 ohn /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Himore mD BAYLLOW Hospite If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex Social Security Number **Funeral** Days Months 1 → 1 2 F -34-0204 116 1936 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location r 28a-f show notified at 10b. County 10a, State 1 ☐Yes 2 No Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural", or items 23a or dical Examiner must be 21222 USA 1535 Leslie Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Police filed within 7 Hygiene. College (1-4or 5+) than Elementary/Secondary (0-12) Police Officer Department 12 years 1 and 2 should be filed wi Health and Mental Hygier sm 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be Sophia Markowski John William Markell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is:
any injury or other trau 1535 Leslie Road, Dundalk, Maryland Kathryn Markell wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cemetery Baltimore, Maryland 15, 2007 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): Examiner Carre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a consequence of) Examiner burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No certificate 2XNo 1 ☐ Yes 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director. Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28h Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No r death. 2 Accident 24 hours after death Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760, be P.0. The law requires that the Division or Vital Records, Hospital or Attending Physician;

72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

within 24 hou

To the Fune

completely fi

the

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Gregory (7char) 31. Data Filed (Month, Day, Year)

SEP 1 2

(7chaus

30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

Bayview Hospital

32. Registrar's Signature

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and majorer stated.

29c. License number

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue Billimore MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend #5 Per Inf. State of Waryland / Department of Health and Mental Hygiene Registrar Reg. No. 2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Fredrick Andrew Marburg /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Rosedale Center Paltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 214ci26ec7437umber 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours March 15: 1930 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 es 2 No Director Baltimore Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e 21205 USA 1205 Horners Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iter Affiled Folces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No altimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced er than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housing Roofer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McDonald Ramond Wahl Eleanore ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) , MD ZIZOS 1 wife Baltimore Rosalie 1205 Horners Lane Marburg 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If Its any Injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy 6 ifts Registry September 19 0007 Hanever, No. 22. Name and Address of Politing Anatomy 6 ifts Registry September 192007 Hanever, MD 4 Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 7522 Connelley Drive Suite P. Harover, Mb 21076 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Difficile Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Trector: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D65152 Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar odele

31. Date filed (Month, Day, Year)

rank

32. Registrar's Signature

ware Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 29209 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician SEPTEMBER 8 07 Lassiter Miller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** St. Agnes Hospital Baltimore n/a If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 239-38-1179 Director 81 5-3-1926 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notified at 1

Yes 2□No Directo MD n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3041 Walbrook Avenue 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify. African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Longshorenan Steamship Trade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Miller Blanche Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Hyla Margaret Miller/Wife 3041 Walbrook Avenue, Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State Woodlawn Cemetery 9-14-07 Woodlawn, MD 22. Name and Address of Facility Wylie F/H P.A. of Baltimore County mature of Funeral Service Licenses Panden 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caus in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular Physician ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown signed by t <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2□! Vital [certificate 2□ No 2 No Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 🗹 📉 2 ER/Outpatient 3 DOA Inpatient Division or After this Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

0

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Meekins September 10,2007 10 = 50 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Harbor Hospital Baltimore, If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Date , 19921 Birthplace (State or Foreign CouMaryland 5. Social Security Number 212-18-0751 6. Sex**X** 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days 86 Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hyglene. Important: if Item 27 is marked other than "naturel", or Itama 23a or 28a-f show any Injury or other treumatic event, Ite Medical Examiner must be notified at once. N/A Baltimore Maryland 1 ☐ Yes 2 ☐ No **Funeral Director** 10g. Citizen of What Country? U.S.A. 10e. Street and Number 2433 Westport Street 10f. Zip Code 21230 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 194
If Yes, Give 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1941 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Black Baltimore, Maryland 21215-0036 Specify: Completed by 1945 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TUCK Driver 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Trucking Company Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) William A. Meekins 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type, Print) Ethelene Johnson God-Sister 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 2433 Westport Street Baltimore, Maryland 21230 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Crownsville Veterans Cemetery 09/17/07 Crownsville, Md. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name} Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 21. Signal/re of Funeral Service Vicenses Approximate Interval Between Onset and Death 29a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Urosepsis Shock **Physician** 20 minutes /Medical Due to (or as a consequence of) **Examiner** Infection) weeks Urinary fract Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physicien and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by hypertension diabetes mellitus dementia 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 ANO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) atient Medical Certification; To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours aftar death. To the Funeral Director; A completely filled in by the fo investigation М 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Michelle Kim muliletim RES DOI September 10,2007. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD S. Hahover Sf 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Janks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** September 7. 2007 Jean Elizabeth Magnaye 626 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Hospital Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F 219-40-6005 01-09-1943 Director 64 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Harford Jarrettsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1406 Buckthorn Drive 21084 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Merle Phenicie Thelma Quarter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rudy Magnaye (Husband) 1406 Buckthorn Drive Jarretssville, MD 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial 09-11-2007 Fallston, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Kine ste ور 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) bastric **Physician** 18 mos /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 2,**X**No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA 1 🗌 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760. Division or Vital Records, P.O. Hospital or Attending Physician: 24 hours after death Funeral Director:

death with the Maryland

Maryland 21215-0036

Baltimore,

200

Marnaye

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

SEP 1 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3718 NORIZISVILLE RD, SUITE C, VARRETTSVILLE MD 2N84 A. WALSH 31. Date filed (Month, Day, Year)

nde a Walsk

and manner stated.

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

34208

29d. Date, signed, (Month, Day, Year) 9/7/2007

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DIVISION	r Atte er deg recto by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		Place	of injury - At h	nome, farm, st	reet, factory, office		28	Bf. Location (S. City or Town	treet and Ni n, State)	umber or Rur	al Route Number,				
5	italoo rs afte ral Di	Cer																
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	edical	29a. Certifier 1 Certifyli (Check only one) 2 Medical	Examiner: Or	the ba	sis of examin	owledge, dea ation and/or ir	th occurred at the tinvestigation, in my	me, date a opinion, de	nd place, ar ath occurre	nd due to the o d at the time, o	ause(s) and date and pla	d manner as s ace, and due	stated. o the cause(s)				
	o the ithin 2 o the o the implei	Med				er stated.		29c. Licens	se number		2	29d. Date si	gned (Month,	Day, Year)				
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1			30 Name and andress of person	who complete	d cause	of death (Ite	m 23a) (Tvne	Print)	, ,	10	-	2611	UNIOE	1,2007	1			
	6		DANIEUE NOBER	MANI	ND	6565	N CHA	PRIES ST	84.17	E 216	. BAC	TIMOR	E, MA	21204				
	Sta	ite	31. Date filed (Month, Day, Year,		32. Re	egistrar's Sign	ature	18/ H			1							
	Regist	ar	30. Name and address of person OAN/EUL DUBLE 31. Date filed (Month, Day, Year,	2007		perd shill	a started to											
				-														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4:49

9. Birthplace (State or Foreign

10d. Inside City Limits 1 ☐ Yes 2 ☑ No

UKRAI NE

WHITE

2007

U.S.A.

Specify:

14. Race - American Indian,

Black, White, etc.

UNKNOWN

1. Decedent's Name (First, Middle, Last) Aleksandr 2. Date of Death Markus SEPTEMBER 9 **Physician** MARKUS **ALEXANDER** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE REISTERSTOWN 12 PUTMAN COURT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day Year 08/14/1949 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 □ F 58 Director 117-80-6274 Usual Residence of Decedent with the Maryland 10c City Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County Director MD BALTIMORE REISTERSTOWN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12 PUTMAN COURT 21136 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3altimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MARINE ENGINEER GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ ARKADY MARKUS ALEXANDRA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SVETLANA MARCUS / WIFE 12 PUTMAN COURT - REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CONG 09/11/2007 REISTERSTOWN, MD □Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the Immediate Cause (Final Physician Hanging disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred or Attending Suicide by Hanging 1 🗌 Natural 5 Pending investigation September 1 2007 14 419 M 1 = 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 X Suicide 4 ☐ Homicide Home Reisterstown, Md To the Funeral 29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

Year

Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

September 10, 2007 MD GTrimble Hill CT. Luther ville Md 21093

State Registrar

(Check only one) 29b. Signature and

title of certifier

018667

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Elsie P. Morin septembs: 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Lover Hospita If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In vrs. last birthday) **Funeral** 1□ M 2**X**F Months Days Hours 530-18-9278 Director 6-16-1915 England Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Ħ MD Prince George's 1 ☐ Yes 2 No ral", or Items 23a or 28a-f sh Examiner must be notified Mitchellville Director 10f. Zip Code 10g. Citizen of What Country? 10450 Lottsford Rd. #3118 20721 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married r than "natural", or i 1 □ Yes 2 No Saltimore, Maryland 21215-0036 Specify: Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than 'arry or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Pauley Mary Ann Warine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Glossop/daughter Department of Health a Important: If item 27 is any Injury or other tra once. 195 Dunn Av.Toronto Ont. Canada M6K2S1 20a. Method of Disposition
1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Chesapeake Crematory 9-8-07 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W135 Rapp Funeral & Crem.Sv.933 Gist Av.Silver Spring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Necle **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Land Land Land Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2☐ No ed by the a 9□Unknown 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2PINO 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 perform certificate To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28d. Describe how injury occurred Fell in by the funeral 28a. Date of Injury 28b. Time of Certification; 27. Manner of Death 28c. Injury at Work? 10,00 M After (Month, Day Year) 1 ☐ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. July 25, 2007 2. Accident 24 hours after death e Funeral Director: lace injury -6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Colling Fan ASSITER Living Mitchelville Many and At home, farm, street, factory, office determined 4 - Homicide building, etc. (Specify) Assisted A 55 is test living Living Mitcleville M filled 29a. Certifier Medical within 24 hor To the Fune completely fi 22 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

W

State Registrar

>A(VAdo

31. Date filed (Month, Day, Year)

Hos

3001 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert George Ni		el - For State	Sta	ate of Maryl		epartme Certifica			and	Mental	Нус	giene	g	^ •		,	
Physician		Registrar 1. Decedent's Name	(First Middle	i ast)			le oi	Deau		-	12	Date of Dea	leg. No.	28	Ų,	Time of I	921
Medical Examin	er	Robert		George		Nicke						Month Septemb	Day er 8, 200			1750 h	rs
, ,)		4a. Facility Name (if Atlantic Gen			umber)		41	o. City, Tow Berlin	n, or Lo	ocation of D	eath		1	ounty of D rcester	eath		
Funeral		5. Social Security Nu		6. Sex		yrs. last birth	day)	If Under 1		If Under 2	_	8. Date of Bi	rth (MM/DD		. Birthi	olace (Stat	e or
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1 of Vii Jing Physia After this funeral dir	<u></u>	1 Yes 2 27. Manner of Death			Inpatient 2 e of Injury	2 🗹 ER/Out	patient me of In		,	at Work?		Home 5 8d. Describe	Residence		Other:		
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Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending phy completely filled in by the finneral director, page 2 should be detached for use as the terms.	Medical	(Check only		ysician: To the be niner: On the basis and manner	of examinati												
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£ .	/Medic		ADA GAYE PARSON 4a. Facility Name (If not institution, give		her)		4h. City. To	wn. or Loca	ation of Death	SEPTEMB		2007 County of Dea	3:45	Р
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	and t		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City	y Limits
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30	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. do ther than "natural", or Items 23a or 28a-f show do other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 Ⅸ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	ces? 2 🔼 No	'	Vas Deceder f Yes, specify I □ Yes 2 <u>\$</u>	Cuban, M	nic Origin? (Spo lexican, Puerto pec <i>ify:</i>	ecify Yes or No Rican, etc.))-	14. Race - Am Black, Wh Specify:		
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Dall	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatte.		21. Signature of Funeral Service Licens	Herch	1	22 N	Name and A	Address of Fune	Facility eral Ho	me, P.A	A.		and 2100	
۲	×		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that ca	used the deat ch line.	h. Do not ent	er the mode o	of dying, su	ich as cardiac	or respiratory a	arrest,	1 1111	Approximate Interval Betv	e veen
€ I	Physician		Immediate Cause (Final disease or condition	a 51	25								Onset and D	eath
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	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Example 1		sis of examina)
	To th withir To th comp	Me	29b. Signature and title of certifier					icense nui			29d. Da	te signed (Mo	nth, Day, Year)	
			David 5	0			3	33	279		JCP	rember.	10,20	P6
	6		30. Name and address of person who o					A T.D.	2101/					
	Sta	ite	DR. DAVID DUNN - 6 31. Date filed (Month, Day, Year)	32. Re	ACPHAL gistrar's Signa	ature,	- BEL	AIK,	21014					
l	Registr		31. Date filed (Month, Day, Year) SEP 1 2	2007	USAN	13		9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Õ9 2007 /Medical institution, give street and number County of Death Examiner ince ocor Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex If Under 1 Year **Funeral** Min. Days Months Hours Director 207-16-8006 82 April 25, 1925 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits must be notified at **Funeral Director** 1 ☐ Yes 2xx No Maryland Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21054 1452 Defense Hwy USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner any once. Black, White, etc. 1 ☐ Yes 2 **K** If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: Be Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Robert Edward Stewart Mary Ellen McMahon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Knight- daughter 1452 Defense Hwy, Gambrills, Maryland 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 9/11/2007 Catonsville, Maryland 21. Signature of Fuler | Service Licensee 22. Name and Address of Facility Fleck Funeral Home, INC. 7601 Sandy Spring Road, Laurel, MD 20707 WYW M01234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -hronic Years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dise to for as a consequence off or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown After this certificate has been signed I funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 🗆 No 3 Probably 4 □Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? oronau 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natura₁ 2 ☐ Accident 1 Yes 2 No Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral

> State Registrar

(Check only one) 29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

Danny Lee, MD \$317 Cherry

31. Date filed (Month, Day, 32. Registrar's Signature Year) SEP

29d. Date signed (Month. Dav. Year)

		4	For State Registrer	State o	f Marylan		artment <i>tificate</i>					iene g. No.2	007	29218
	Physicia	an	1. Decedent's Name (First, Middle, Las Robert C. Robey)							2. Date of Death Sept 7,	2007	Year	3. Time of Death 5:35P M
	/Medic Examin		4a. Facility Name (If not institution, give 6708 Coolridge I		n <i>ber)</i>		4b. City, 1 Temp			of Death			inty of Death	eorge's
	Funeral Director		5. Social Security Number 6. Social Security Number XXX	M 2 F	7. Age (In yrs. I	last birthday) Yrs.		1 Year Days	If Under Hours	Min.	8. Date of Birth Month, Day, May 5,	1926	9. Birth Wash	nplace (State or Foreign untry) lington DC
	aryland show	2	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	orgo!s		y, Town or Lo								10d. Inside City Limits 1 ☐ Yes XX No
	with the M s or 28s-f be notified	Directo	10e. Street and Number 6708 Coolridge		161	mpic II.	10f. Zip	Code 0748			10	•	of What Co ted St	
٥	n 72 hours after death with the Maryland *naturel; or Items 23a or 28a-f show walcal Examinar mast be notified at	Funeral Directo	11. Marital Status 1 Never Married 2 Married	12. Was Dec	edent Ever in U. prces? 2 No WW	TT '	f Yes, spec	ify Cubar	spanic Ori n, Mexicar Specify:	n, Puerto F	cify Yes or No- Rican, etc.)		Black, White	
9500-612	72 hours a naturel', o	eted by	3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra	Year or D	rates:	16a. Dece	1 ☐ Yes a dent's Usua kind of wor DO NOT us	l Occupa	tion uring mos				ecify: Whi	
N	be filed within 72 Ital Hygiene. d other than "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Litho	_	er		odo Alomo	(First, Middle, M	Prin		
Maryland	uld be fill dental Hy rked oth	To Be	17. Father's Name (First, Middle, Last) Robert C. Robe	∍y					Matt	ie E	. Kay			
Mary	as 1 and 2 should to of Health and Ment item 27 is marked rother traumatic		19a. Informant's Name/Relationship (Valintine M. Bowe		Wife)						Route Number emple Hi			
nore,	Peges 1 er nent of Hea int: If Item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)	Removal from	State 20b. P	Place of Disponentery, cremetery, cremetery								Town, State ryland
Baltimore,	permit. Peges Depertment of I Important: If it eny injury or o		21. Sign Tue Funeral Service Licer	see	10/39	22	2. Name an	d Addres	s of Facili	ty Lee		Home	e, Inc	6633 01d
-	Married Marrie		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that	aused the deat	h. Do not ent			g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
s	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	(or as a conseq		PULP	Y						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conseq	quence of):								
,097	ate be executed hysicien and the burial-transit	ical Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	quence of):		wh						
89	aath certificate attending phys for use as tha		IF FEMALE:	23c. If ves. ou	itcome of pregna	ancv		SUTTE:			-	23d	. Date of de	livery
.O. Box	0 0	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live	birth 2 ☐ Feta nant at time of c	al death 3	⊒Ectopic pr ⊒ Other (sp						Month	Day Year
Δ.	uires thet signed by Id be deta	<u>م</u>	Part II. Other significant conditions of	ontributing to o	leath but not res	sulting in the L	underlying o	ause give	en in Part	I.	23e. Did to	_		o the cause of death?
Records,	The law requires thet the ste hes been signed by the page 2 should be detache	Completed									24a. Was a autops perform	in 2 sy med? 2 No	24b. Were au prior to death? 1 \(\sum \text{Yes}	utopsy findings available completion of cause of
Vital		9	25. Was case referred to medical examiner?	Hospital:				Othe	200		(Check only or			
6	ding Physi h. After this o tuneral din	. To	1 ☐ Yes 2 🔼 No 27. Manner of Death	1 _	Inpatient 2 of Injury oth, Day Year)	28b. Time of		28c. Injun Worl	4 🗆 14		me 5 Residence 128d. Describe h			ecify)
Division of	or Attending Physician: efter death. Director: After this certific in by the funeral director,	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e 28e. Plac	e of Injury - At h	nome, larm, st	М	10	Yes 2□		28f. Location (S City or Tow		lumber or R	ural Route Number,
ō	To the Hospital or Attenwithin 24 hours efter deat To the Funaral Director: completely filled in by the		29a. Certifier 1 TX Certifying Pl	rysicien: To the	e best of my kn	owledge, dea ation and/or in	th occurred	at the tin	ne, date a pinion, de	ind place,	and due to the o	ause(s) ar	nd manner a	s stated. e to the cause(s)
Ž.	To the P within 24 To the F	Medical	29b. Signature and title of certifier	and ma	nner stated.	0.41		c. Licens	e number					th, Day, Year)
,	di		30. Name and address of person who	completed car	LULAU use of death (Ite		, Print)			299			Thu	100070
	l ¹	ate	ALI RAHIM 31. Date liled (Month, Day, Year)		Registrar's Sign		- 0		LTT	ROAL	205	CLIN	Non	MD 20/35
	Regist		SEP 12	2007	Elmen	J. A	park	9						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-06946 State of Maryland / Department of Health and Mental Hygiene 2007 29219 Damontay Rush Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day September 7, 2007 0645 hrs Damontay Rush Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Country) **Funeral** Months Days Hours Min. Director Yrs 5 1 X M 2 F 2 July 12 none Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any 1 XX Yes 2 No 28a-f show MD Baltimore must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 817 N. Monroe Street 21217 USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 12. Was Decedent Ever in U.S. Funera 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. items Armed Forces 2 Married 1 X Never Married $_2XX$ Yes African American Yes 2 X No specify Yes, Give Year "natural", Widowed Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. ted Elementary/Secondary (0-12) College (1-4 or 5+) d other than ", n/a Baltimore, MD 21215-0036 0 0 n/a 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shakia Rush Michael Gaffney is marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shakia Rush / Mother 817 N. Monroe Street; Baltimore, Maryland other tranmat 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State King Memorial Park 09/13/2007 Randallstown, MD Donation 5 Other Specify 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee cues 638 N. Gilmor Street; Baltimore, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death 'Medical Sudden Unexplained Death in Infancy Immediate Cause (Final disease xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit hysician/Medical X UNPENDED AMENDED, #23a.27.28a-f. perME.g872, 10/26/07 TT ed by the attending physician detached for use as the burial 23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE Day Year Month Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 V No 3 Probably 4 Unknown signed b ğ Completed 24b. Were autopsy findings available 24a, Was an has been si prior to completion of cause of autopsy death? performed? No ✓ Yes 2 1 🗸 Yes page certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Nursing Home 5 Residence 6 DOA Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred After the 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death Certification: Yes 2 X No 1 Natural unk Pending Fnd 5:00 am Fnd 9/7/2007

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, filled in by the f 24 hours after death. To the Funeral

2

3

29b. Signature and tile of contifier

Medical

State Registra

Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be or Town, State) N. Monroe St. Baltimore, MD Suicide determined (Specify) Found at residence Homicide Certifying Physiciam: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

29d. Date signed (Month, Day, Year)

September 8, 2007

Mary G. Apple MD. trar's Signature 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007

Certificate of Death 29220 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death

Phy /N Ex

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physic /Med Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760,

/sicia ledic		Barbara Singl	September 11, 2007 11:45 A ^M
min		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
222		7927 Lynch Road	Dundalk Baltimore
eral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min. (Month, Day, Year) Country)
tor		216-20-4674	July 23, 1926 Maryland
_		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or I	Location 10d. Inside City Limits
ed al	or	Maryland Baltimore Dundal	1 □Yes 2XNo
TIO	Directo	Maryland Baltimore Dundal	LK 10f. Zip Code 10g. Citizen of What Country?
e		7927 Lynch Road	21222 USA
snu	Funeral	<u> </u>	
iner	Fun	1 □ Never Married 2 □ Married 1 □ Yes 2 ΪXNo	3. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
-xar	þ	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 □ Yes 2 No Specify: Specify: White
cal	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Git	sedent's Usual Occupation 16b. Kind of Business/Industry
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vent	æ	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
atice	L ₀	Carl Russ	Eva F. Ortel
anu		1 1 // /	iling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
her ti			Lynch Road, Dundalk, Maryland 21222
o o			position (Name of ematory or other place) September 20c. Location - City or Town, State
nu l		4 Donation 5 Dottler (Specify)	Park Cemetery 14, 2007 Baltimore, Maryland
any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A.
W 01			7110 Sollers Point Road, Dundalk, MD. 21222
		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	Onset and Death , I
ian		Immediate Cause (Final disease or condition resulting in death)	plastic syndrome 3 months
cal ner		Due to (or as a consequence of):	J
	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
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completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Examiner	that initiated events resulting in death) Last c	
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as the	sician/Medical	U	
nse	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	23d. Date of delivery
a to	icia	in the past 12 months? 1 Veg. 2 PAIs 4 Pregnant at time of death	B ⊟Ectopic pregnancy Month Day Year 5 ☐ Other (specify)
achei	-	9 ☐ Unknown 9 ☐ Unknown	
e det	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
			1 ☐ Yes 2♥ No 3 ☐ Probably 4 ☐ Unknown
2 sho	plet		24a. Was an 24b. Were autopsy findings available
age	Completed		autopsy performed? death? □ Yes 2♥️ No □ Yes 2♥♠ No
tor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
direc	To E	1 ☐ Yes 250 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
nera	.:uc	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	
he tu	atic	2 Accident investigation	M 1 Yes 2 No
n by t	Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
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tely h	edical	(Check only 2 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
Hple	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
8	_	to to Contract	N11/118 1 + 12 th 2007
		and with the	1 246110 Jeh 12 2001
7		30. Name and address of person who completed cause of death (Item 23a) (Typ	York Rd Lutheralle MN 21092
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	y of the following from the state of the sta

Registrar

			1 - For State Registrar	State of M	laryland	1 / Dep <i>Ce</i>	ertificate of L	ealth and l Death		ien200	7 29221
	Physici	an	1. Decedent's Name (First, Middle		0 1	1			2. Date of Deat Month	Day Yes	
	/Media	al	Melissa E			nde		1	Septenh	279,20	
	Examin	er	4a. Facility Name (If not institution 3507 Dillon		,		4b. City, Town, or	1+imoc		4c. County of D	timore
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. la	st birthday	If Under 1 Year	If Under 24 Hrs	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		218-74-1165	1□M 2MF	49	Yrs.	Months Days	Hours Min.	(Month, Day, March		laryland
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or I	ocation				10d. Inside City Limits
	Maryl	tor	Maryland Bal	timore		3	ultimore				1 XYes 2 □ No
	r 28a	Director	10e. Street and Number			-	10f. Zip Code		10	0g. Citizen of What	Country?
	th wit	al D	3507 Dillor	Street			2	1224		US	A
	er dee	uner	11. Marital Status	12. Was Decedent Armed Forces' ied 1 Tyes 2	Ever in U.S	. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- o Rican, etc.)		merican Indian, /hite, etc.
36	irs aft	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	led 1 ∐ Yes 2 N If Yes, Give Year or Dates:	No		1 ☐ Yes 2 No	Specify:		Specify:	White
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or items 23s or 28s-f ahow ha Madigal Examinal roual be notified at	ted	15. Deceden	's Education		16a. Dec	edent's Usual Occupa	ation	4	16b. Kind of Busine	ss/Industry
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7	filed w Hygier other th		17. Father's Name (First, Middle,	(and			Waitre		- (5)-4 44:4-4- 4		zurant
Maryland	d be find be cod of	Be C		Selander					ne (First, Middle, A	Edler	
چ	should I nd Men marke umatic	To	19a. Informant's Name/Relations			19b. Mai	ling Address (Street a				
	and 2 Belth a n 27 ls		Shirley Selan	der / Mot	her	350	7 Dillon	Street	+ Baiti	more, N	D 21224
Baltimore,	of He of He if Item or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation		20b. Pla	netery, cr	oosition (Name of ematory or other place	9)	Date	20c. Location - City	or Town, State
Ē	Pages tment of I tant: If it		4 Donation 5 ☐ Other (S	pecify)	Ana	tomy	Citts Regi.	stry Septe	nbe-9,2007	Hanove	r, MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28s-f show apportant: or other traumatic event, the Medical Examinar must be notified at QBDs.		21. Signature of Funeral Service	Deunsee		7	2. Name and Ad Tes 1522 Conne	lley Driv	natomy G 2 Suite P.	Hanover,	MB 21076
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each I	ine.				or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. Me	Post	ic	Faihr	_			Onset and Death
	/Medical Examiner		, , , , , , , , , , , , , , , , , , , ,	Due to (or as	a conseque	ince of):	(0)				
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	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	C							
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68760,	ificate be executed g physicien end as the burial-transit	edlcal		d							
	eath certifi attending for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan	су				23d. Date of	delivery
. Box	death e atte	Physician/M	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			□Ectopic pregnancy □ Other (specify)			Month	Day Year
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Division of Vital Records, P.O.	The law requires that the death cert sie hes been signed by the attendin page 2 should be detached for use	þ	Part II. Other significant condition	ns contributing to death t	out not result	ting in the	underlying cause give	en in Part I.		_	e to the cause of death? Probably
Sor	w requir been si should	letec							24a. Was ar		
Be	he lav e hes age 2	Completed							autops: perform	y prior ned? death	autopsy findings available to completion of cause of 1?
tal	an: T	0	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes 2 ath Check only one	<u></u>	′es 2□ No
>	hysicl lis ce	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpati	ent 2 □ E	R/Outpatie	ent 3 DOA Othe		The State of the S	nce 6 Other (S	pecify)
ם ס	Attending Physiclan: r death. sctor: After this certifice by the funeral director, g		27. Manner of Death 1 Satural 5 ☐ Pendin	28a. Date of Inju (Month, Da		28b. Time Injury	Work		28d. Describe ho	w injury occurred	
Sio	ttendi death. tor: A	cat	2 Accident investig	ation	ina. Asbar			res 2□No	006 1		010
<u>></u>	after Direction by	Certification:	4 ☐ Homicide determ	building, e	tc. (Specify)	ne, iarm, s	treet, factory, office		City or Town	, State)	Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the best Examiner: On the basis of and manner st	of examination	ledge, dea on and/or i	ath occurred at the tim	e, date and place pinion, death occu	n, and due to the ca erred at the time, da	use(s) and manner ate and place, and o	as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie	1			29c. License			d. Date signed (Me	
<	><) Ma Cr	lux			n-	2792	-	9/10	107
l	D		30. Name and address of person			23a) (Type			dalk, 1		.222
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	rar's Signatu		1				
	Registr	ar	SEP 1	2 2007	8 4 h 12 B	15	Brank &				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 7 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician SPARROW SEPTEMBER 05 2007 2:50PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner RANDALLSTOWN BALTIMORE HOSPITAL CENTER NORTHWEST If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2√5√1 79 28, Director 1927 Kentucky 401-40-7717 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a, State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2XXNo Director Randallstown MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a 21133 United States 3830 Brownhill Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【X No If Yes, Give 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes XX No If Yes, Give Year or Dates: Specify: Specify: White þ 3 NWidowed 4 □ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetoligist 12th Hairdresser 12 should be filed w h and Mental Hygier 7 is marked other tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Rasnick William Coleman Pages 1 and 2 should ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is,
any injury or other trau 1940 Littlestown Pike Westminster, MD 21158 Warren R. Sparrow(Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 9/10/2007 Sykesville, MD 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory, 1
1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACCIDENT CEREBROVASCULAR **Physician** a. MASSIVE Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? IN PECTION TRACT 24a. Was an UNNARY page 2 s autopsy performed? Yes 2 No certificate 2□No 1☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 1 Tes within 24 hours after death.

To the Funeral Director: After this funeral 27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation 1 □ Yes 2 □ No filled in by the 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated December 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier SEPTEMBER 05 42723 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWEST HOSGITAL CENTER. 12 ROMA HARLSH. AVVERAHALLI 5401 21133 OLD COUNT 32: Registrar's Signature 31. Date filed (Month, Day) State Registrar

			State of Maryland / Depart State of Maryland / Depart Certification	tment of Health and Me	ental Hygiei	ne No 2007	29223
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
37	Physicia /Medic		Diane Elizabeth Seymour	S	sept 0	6 ^{ay} 2007	9:05 PM
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		2-	611 North View Road	Mt. Airy If Under 1 Year If Under 24 Hrs. 8	3. Date of Birth	Frederick	ace (State or Foreign
	Funeral Director			Months Days Hours Min.	Month, Day, Ye	ar) Couin	try)
		ŀ	Usual Residence of Decedent		DI 20 13		
	rrylan show	_	10a. State 10b. County 10c. City, Town or Local			11	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he Ma 8a-f s	Director	MD Frederick Mt. A	1 TY 10f. Zip Code	100	Citizen of What Coun	
	a or 2	ä	10e. Street and Number			Oluzeri di Wilat dali	
	ns 23	Funeral	611 North View Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	21771 as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto R	US tify Yes or No-	14. Race - Americ	
9	after o		1 Never Married 2 1 Married 1 1 Yes 2 1 No	Yes, specity Cuban, Mexican, Puerto H □ Yes 2\\ No Specify:	ican, etc.)	Specify: Bla	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		400		
15-("natı	Completed	(Specify only highest grade completed) (Give ki	nt's Usual Occupation ind of work done during most of workin O NOT use retired)	9	. Kind of Business/Inc	lustry
12	within jiene.	omp	Elementary/Secondary (0-12) College (1-4or 5+) 12 Claims	Processor	F	irst Morto	age
br	be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Surname)	
ylaı	should be nd Mental marked o	To	James White	Julia		Gil	
Maryland	ages 1 and 2 should b nt of Health and Ment :: If Item 27 is marked r or other traumatic e			Address (Street and Number or Rural			Code)
	1 and Healt em 2		20a Method of Disposition 20b. Place of Disposition	orth View Road, Mt		MD 21771 Location - City or To	wn, State
JOL	Pages nent of I ant: If Its ury or o		1 Note 1 N	atory or other place) e Cemetery Sept 1	2 2007	Mt. Airy ,	MD
Baltimore,	± ± € = .			Name and Address of Facility Burn			
m	permi Depar Impor any ir		self- Kellin 12	12 W. Old Liberty	Road, Wi		
П			29a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
8	Physician		Immediate Cause (Final disease or condition resulting in death) The The The Translation as a second resulting in death)	BREAST C	ANCET	_	IYEAV
ſ	/Medical Examiner		Due to (or as a consequence of):				
	, s _e : [er	Sequentially list conditions, if any, leading to immediate b				
3).	cuted ad ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c				
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	death e atter d for u	iciai	in the past 12 months? 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
P.0	that the de sed by the a detached t	hys	9□Unknown				
	igr be	by F	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobac	co use contribute to th	
Orc	v requir been si should	eted					
Vital Records,	e lav has je 2	Completed			24a. Was an autopsy performed	prior to condeath?	psy findings available mpletion of cause of
<u>[a</u>	, in 12		25. Was case referred to medical	26. Place of Death	(Check only one)	No 1 □Yes	2 2 No
>	Physician: this certificral director,	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othor	-	e 6 □Other (Specif	y)
n or			27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at 2 Work?	8d. Describe how	njury occurred	
sio	Attending ir death. ector: Afte by the fune	catio	2 Accident investigation	M 1 Yes 2 No	Of Legation (Care	towal them became Bear	J Pouto Alumbos
Division	or At after d Direc in by	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	et, factory, office	City or Town, S	t and Number or Rura tate)	i noate Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	alCe	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death				
	the Ho hin 24 h the Fu upletely	edical	(Check only one) 2	estigation, in my opinion, death occurre	ed at the time, date	and place, and due to	o the cause(s)
	To the to the total	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
•) LWH	D 47951		2-10-2	
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, P	11 1	- REDERI	CK, MD	21701
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 2 2007				

DHMH 17 Rev 1/2001

07-06996 Winston E. Scott

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 29224

		I- For State Registrar		Certificate of Death							Reg. No.			
Physicia Medical Examin	ın/ ner	1. Decedent's Name (First Winston			E.		Sco	ott			Date of Death Month September	Day Yea 8, 2007	ır	3. Time of Death 2250 hrs
		4a. Facility Name (if not in Howard County (_		umber)		41	o. City, Town, o Columbia	Locătion o		la.	4c. County of Howard	of Death	
Funeral		Social Security Number	6. S	ex	7. Age (In	yrs. last bi	rthday)	If Under 1 Yes			B. Date of Birt	(MM/DD/YYYY	9. Birth Foreign	nplace (State or
Director		240-19-1547		X M 2 F		36	Yrs.	Months Day	/s Hours	Min.	1-20-	-1971	Cou	intry) N.C.
an y	H	Usual Residence of Deced 10a. State 10b. C			10c.	City, Tow	n or Locatio	n						10d. Inside City Limits
★ .1	ō	Md.	NA	<u> </u>		I	Baltin		i i		Eco. 1			1 X Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once	Director	10e. Street and Number 1607 E. 28	8th St	reet				10f. Zip Code 212.	18		10	g. Citizen of Wr USA		try?
hours after death with the Maryland natural", or items 23a or 28a-f shi Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2		Armed I	2 x			Decedent of H s, specify Cuba				White	e, etc.	can Indian, Black,
after	à	3 Widowed 4		d If Yes, Give Ye or Dates:	ear			Yes 2X N			4-71	Specify:		
hours afte 'natural", Examiner		15. Decedent's Educatio				ed) 16a		s Usual Occupa st of working life				16b. Kind of Bu	siness/Ir	ndustry
036 rithin 72 ene. er than "	Completed	Elementary/Secondary 12th grade	9	2 yrs	(1-4 or 5+)		Cool	ς				Mercy 1	Hosp	ital
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, th. M diva	å	17. Father's Name (First, I			So	cott				s Name (Fi		laiden Surname Ponto		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' or other traumatic event, the Nt dival	٩	19a. Informant's Name/Re Elliott So		Type, Print) Fat	her	1						ber, City or Tow More, Mo	d.	21218
ore, es l an of Heal If iten		20a. Method of Disposition 1 Burial 2 Cre		Removal	from State	crema	atory or other		· 1		Date	20c. Location	-	
Baltimore, permit Pages I at Department of Hee Important: If ite		Donation 5 O	ther Specifi	y:		Cris		Cemeter			5 – 07	1	Ke K	apids, N.C.
Bal permi Depai Impo injur	1	21. Signature of Fullerars	Ne Lice	last	ltey 1101 E. North Aven							H. East	БМ	21202
Physician	7	3. Part I. Enter the dise	Enter the disease, or complications that caused in death. Do not enter the mode of dying, such as cardiac c								espiratory arre	est, shock, or he	art	Approximate Interval
* /Medical xaminer	1	failure. List only one cause on each line. Between Onset and Death mediate Cause (Final disease roundition resulting in death) Due to (or as a consequence of):												
	1	r condition resulting in d	eath)	Due to (or as	a conseque	ence of):			• 15	-	95 01			
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be exitian	n/Medical	XUNPENDED		#23a	PII.27.	perME.	g872. 1	0/26/07	IT					
~~ ← ⇔	Š	IF FEMALE: 23b. Was decedent pregna	ant in the	230. If yes	s, outcome o	i pregnanc	y	al death 3		nreananc	v	23d. Date of Month		/ Day Year
9.0. Box 6876 that the death certificate ned by the attending phy detached for use as the	Physician	past 12 months?		4 Pre	gnant at time			er (Specify)	Lotopic	pregnanc	у	Month		Jay Teal
Bo e deat the at	hys	1 Yes 2 No 9	Unknow	9 Onk	nown									
P.O.		Part II. Other significant		•	to death but	t not resulti	ing in the ur	nderlying cause	given in Pa	irt I.				the cause of death?
IS, F quires en sign	Completed by	Seizure d	ısorde	<u> </u>							24a. Was			topsy findings available
cords, law requir has been s	ple					-		_ 			autop	sy		completion of cause of
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of Vital Recing Physician: The After this certificate funeral director, page	P	1 ✓ Yes 2 1 27. Manner of Death	No	'_	te of Injury		Outpatient Time of In		ury at Work			Residence 6	Other	···
Sion C Attending death. ctor: Aff	tion	1 X Natural 5	Pending Investiga	(Mor	nth, Day,Year)			′′	Yes 2	. 1		,,		
Division of Vital Records, spital or Attending Physician: The law requir hours after death. Ineral Director: After this certificate has been sy filled in by the funeral director, page 2 should the control of the funeral director.	Certification:	2 Accident 3 Suicide 6 4 Homicide	28e Place of Injury - At home, farm, street, factory, office building, etc.							c. 28	8f. Location (\$ or Town, S		er or Ru	ral Route Number, City
Hos Fur Fur	Medical Co	29a. Certifier 1 Certif		er: On the basi	s of examina							e(s) and manne and place, and		
To the within To the comple	Mec	29b, Signature and title of		and manner	r stated.				nse number	-				nth, Day, Year)
		Pat .	lian	_	PA	0.1		0.0	.M.E.		September 11, 2007			
1		30. Name and address of	•					444.5	.	. 14.	MD 0100	4		
U	ate	Patricia Aronica-			stant Med Begistrar's S		2743	111 Penn S	treet, Ba	aitimore,	NID 2120	-		
	State 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature Registrar CED 1 2 2007													

Amend #1, perMD, C872, 10/15/07 TT State of Maryland / Department of Health and Mental Hygien 007

1- State Registrar Amend 10a&19b, perInf, C871, 9/19/07 CTErtificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Juan Angel Salmeron Month **Physician** Sept. 8, 2007 1:58 a M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Hospital Prince Georges Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 € M 2 □ F 578-15-5145 63 Yrs 27, 1944 Jan. El Salvador Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Medical Examiner must be notified at tX Yes 2 No Director D. C. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 20011 El Salvador 1308 Shepherd Street, N. W. death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 21215-0036 Wayes 2□ No Specify: Salvadoran If Yes. Give 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Cook Restaurant permit. Pages 1 and 2 should be filed w Department of Heelth and Mental Hygien Important: if Item 27 is marked other th. eny Injury or other traumatic access 6th 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Leandro Salmeron Petrona Matamoros 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 308 308 Shepherd St., NW Santos Hernandez (Wife) Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Gate of Heaven 09/13/2007 Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 3447 14th St., N.W. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses W. H. Bacon Funeral Home, Inc. Washington 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) yeens ARDIOVASCULUR MIGNIOSCIENOPLL Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) anding physicien a use as the burial Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. wont Obstructure lung Disons 1 Yes 2 No 3 Probably 4 Unknown Completed Respiratory Fail re/ventiles 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours To the Funeral 12 Contifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated 38a, Cartifler 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sentember 9 2007 Name and address of person who completed cause of death (Item 23a) (Type, Print) reasony Rd Hyg Haville MI) 20781 VOREMA YOUR QU 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2330 09 08 07 SCHMIDT LOUISE ANNA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY WMHS-BRADDOCK CAMPUS CUMBERLAND If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 □ M 2XX June 19, 1914 Maryland Director 442-07-5996 93 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County ns 23a or 28a-f show must be notified at XXYes 2 □ No Director Maryland | Allegany Cumberland 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 222 Union Street 21502 Funeral America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 □ Yes ŽÍŽNo ٥, Baltimore, Maryland 21215-0036 Specify: White þ 3X Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Para Legal Law Firm llth permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If Item 27 is marked other 1 any Injury or other traumatic event, III any Injury or other traumatic event, III and Injury or other traumatic event, III and Injury or other traumatic event, III and Injury or other traumatic event, III and Injury or other traumatic event, III and Injury or other Itanian Injury or other Itanian Injury or other Itanian Injury or Itanian Injury Injur 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Leef Jessie B. Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cumberland, Maryland 21502 222 Union Street; C. Douglas Schmidt (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul's Lutheran Church Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State Sep. 13, 4 □ Donation 5 □ Qther (Specify) 2007 Arcadia, Maryland 21. Signature of Fune & Service Lie 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Immediate Cause (Final dise se or condition resulting in death) Congestive Heart 2 years **Physician** /Medical Due to (or as a consequence of) Examiner-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner for use as the burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be after death. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Failme 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a. Was an autopsy performed 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 1/X Inpatient Medical Certification: To this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funerai D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 55325 09. 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg MD 21532

State Registrar SHIN

WONSOCK

31. Date filed (Month, Day, Year)

Terrace

Tarm

32. Registrar's Signature

48

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2007 Barbara June Carter Smisko Sept 5, 1:20 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 23,1927 Social Security Number 6. Sex Birthplace (State or Foreign Country) Days Hours Tennessee 208 20 1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X☐XNo Directo Maryland Prince George Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6010 Terrence Drive 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 20 No If Yes, GiveX X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes X ☐ No Specify: Specify: White X3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Clerk C&L Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip Carter Gladys Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20735 Lisa Taylor (Daughter) 6010 Terrance Drive, Clinton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Linu 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sylvania Hills MemorialPark Rockchester, Pa 22. Name and Address of FacilityLee Funeral Home Inc6633 01d 21. Signature of Funeral Service Licenses 400153 Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Theresclandic landis vasclar 5 years Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for as a consectioned off: Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 2)K(No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, physician attending esn ρ the signed by t has certificate |

Examiner Physician/Medical Completed Be ၉ Certification:

Medical

Physician

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

the Medical

Hygiene.

Department of Health and Mental Hygic Important: If item 27 is marked other 1 any Injury or other transments.

Physician

/Medical

Examiner

within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

this After the Funeral Director; Af

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the

b.	Signature and title of certifier	
	1 mgh	Μ
١.	Name and address of person who comple	ete

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 ☐ Pending investigation

6 Could not be determined

045365

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Michael SiDAROVI, M.D 1170/ livingstor W #10/ fost W skington MD 70765

31. Date filed (Month, Day, Year) State SEP 1 2 200 Registrar

1 Natural

2 Accident 3 Suicide

4 ☐ Homicide

(Check only one)

29a. Certifier



DHMH 17 Rev 1/2001

		,	1 - For State Registrar	State of Mar	yland		artment rtificate					Reg. No	11111	292	
	Physici /Medic	4.0	1. Decedent's Name (First, Middle, Last Dino G.	s:) Stavropoulc	ns						Date of De Month ptent	Da	10 200		
	Examin		4a. Facility Name (If not institution, give				4b. City, T		Location of Dea			4c	. County of Deal	h	
4	- 100		Good Samaritan 5. Social Security Number 6. S		In vrs. la.	st birthday)	If Under 1		timore If Under 24 Hr	S. 8.	Date of Bir	th	N/A	hplace (State of	r Foreian
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	show	ž	10a. State 10b. County		ioc. City,	Town or Lo								1 ☐ Yes	•
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20	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or litema 23a or 28a-f show event, Ina Madical Examinar must be notitied at	by Funerai	11. Marital Status 1 □ Never Married 2X Married	12. Was Decedent Ev Armed Forces? 1X1Yes 2 ☐ No			Was Decede If Yes, specif		spanic Origin? (n, Mexican, Pue Specify:	Specify erto Rica	Yes or No n, etc.))-	14. Race - Ame Black, Whit Specify:	e, etc.	
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and	be fite tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)						18. Mother's N			_			
2	2 should be and Mental is marked o raumatic eve	၉	George P 19a. Informant's Name/Relationship (na Address /	(Street a	and Number or I		ohia wa Numb		Karang or Town, State, .		
Z Z	id 2 si Ith an 27 is r traur		Mrs. Catherine R.						Avenue				Marylan		
ē,	es 1 and 2 should b of Health and Menti filem 27 is marked ir other traumatic e		20a. Method of Disposition		20b. Pla	ce of Dispo	natory or oth	e of her place	θ)	Date		20c. L	ocation - City or	Town, State	
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Baltimor	permit. Pages Depertment of h Important: If ite any injury or of		21. Signature of Funeral Service Licer	1 Rues	/	1	2. Name and	ork	Road T	owso	on. M	arvl	uneral and 212		nc.
	Physician		23a. Part1. Enter the disease, or com- shock, or heart failure. List on	olications that caused the one cause on each line	1	Do not ent	ter the mode	of dying	g, such as card	ac or res	spiratory a	rrest,		Approximate Interval Bety Onset and D	ween
	/Medical		disease or condition resulting in death)	a. Due to (or as a			VIEL	رر_							
	Examiner	_	Sequentially list conditions, if any, leading to immediate	b. HEM	UVV	rha	GIC	_5	trolle	=					
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9	be executed ician and burial-transit	Examin	that initiated events resulting in death) Last	C Due to (or as a	conseque	ence of):									
100	9 8	ical	(d											
0	certificate nding phys	Medi	IF FEMALE:												
C. BOX	death e atter	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal	death 3	□Ectopic pre □ Other (spe						23d. Oate of de Month		/ear
as, r.	requires that the dei een signed by the a hould be detached fi	ρ	Part II. Other significant conditions of	contributing to death but	not resul	ting in the u	inderlying ca	use give	en in Part I.			tobacco Yes 2	use contribute to	×1	eath? Jnknown
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VII	iclan: Th certificate rector, pag	a	25. Was case referred to medical						26. Place of D		1 ☐ Yes heck only	2) (2) one)	1010	2010	
	S S	To B	examiner? 1 ☐ Yes 2X No	Hospital: 1 Inpatient		R/Outpatie			4 🗀 Nursing				6 ☐Other (Spe	cify)	
n or	er er		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury		C. Injury		28d.	Describe	how inju	iry occurred		
210	Attending Ph er death. rector; After th by the funeral	icati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e Oos Blace of Injur	v - At hon	ne farm st	M reat factory		Yes 2 □No	28f.	Location (Street a	nd Number or R	ural Route Num	ber.
UIVISION	0 # 5 S	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	110, 14111, 50	root, ractory,	Onico			City or To				
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	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c.	License	e number				ate signed (Mon		
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	641		30. Name and address of person who	completed cause of dea	ath (Item	23a) (Type,	Print)	, (Grad S	San	nar	tu	fitenter of Gorp	tal M	D
1000	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 2 2	32 Begistrar	's Signati	ure	make 9							4	1239
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	1	For State of Registrar	Maryland / Depa	artment of H			ne No.2007	
Physicia /Medic	_	1. Decedent's Name (First, Middle, Last) Shirley Yoko Shimomura				2. Date of Death Month 09 0		3. Time of Death 4:30 pm
Examin	_	4a. Facility Name (If not institution, give street and num Holy Cross Hospital 5. Social Security Number 6. Sex	nber) 7. Age (In yrs. last birthday)	4b. City, Town, or Silver Si	Location of Death pring If Under 24 Hrs.	8. Date of Birth	4c. County of Death	У
Funeral Director		5. Social Security Number 577-88-0582 Usual Residence of Decedent	48 Yrs.	Months Days	Hours Min.	(Month, Day, Ye 2-12-195	-	nplace (State or Foreign untry) Jersey
the Maryland 28a-f ehow	ector	10a. State 10b. County ID Montgomery 10e. Street and Number	10c. City, Town or Lo			10g.	Citizen of What Co	10d. Inside City Limits 1 ☐ Yes → No untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If fire X7 Is marked other than "natural; or Items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examinar must be notified at once.	by Funeral Director	1914 Forest Dale Dr.	2 X No	20903 Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:		SA 14. Race - Ame Black, White Specify: As 1	e, etc.
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nd 2 should be flie lith and Mental Hy 27 le marked oth r trsumatic event	To Be	17. Father's Name (First, Middle, Last) David Shin Shimomura 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	Shioko M	e (First, Middle, Mai Lyahara al Route Number, Ci		Zip Code)
oermit. Pages 1 and 2 Depertment of Health a Important: If Item 27 le any Injury or other tres once.		Joseph Bellomy/husband 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from S 4 Donation 5 Other (Specify)	cemetery cre	matory or other plac	e)	207	ing MD2090 c. Location - City or eltsville	
permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee	mo135 8 R		ss of Facility a1 & Cren	n.Sv.933 G	Gist Av.Si	MD20910 Llver Spring
Physician /Medical Examiner physicien and phe purial-Itansit	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		iratory f				Interval Between Onset and Death 1 Week 6 years
death certific e ettending p od for use as i	by Physician/Medical	23b. Was decedent pregnant 1 Live b	ant at time of death 5	□Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
sign d be		Part II. Other significant conditions contributing to de	ath but not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to 2 No 3 □ Pr	o the cause of death? obably 4 □Unknown
: The law requicete hes been ; pege 2 shouk	Completed					24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to death?	utopsy findings available completion of cause of 2 No
To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director; After this certificete hes completely filled in by the funeral director, page 2	Certification: To Be	27. Manper of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	npatient 2 ER/Outpatie of Injury 28b. Time of Injury h, Day Year) Injury of Injury - At home, farm, st	of 28c. Injur World M 1	er: 4 🗆 Nursing H	th (Check only one) ome 5 Residenc 28d. Describe how 28f. Location (Stree	injury occurred	
Hospital or A 24 hours efter Funeral Direction by	Medical Certif	4 Homicide determined 200. Place building 201. Certifier (Check only one) 202. Medical Examiner: On the bar and mann	ng, etc." (Specify) best of my knowledge, daels of examination and/or in	th Jecurred at the tin		City or Town, S	State)	stated.
To the within 2 To the complet	Me	29b. Signature and title of certifier 30. Name and address of person who completed caus	MD		2503	9	Date signed (Mont	7
∖ ^β Sta Registr		Shailesh Sheth, M 31. Date filed (Mortin, Day, Year) 32.	.D. Holy Cro	ss Hospit	al 1500)	Forest Gle	n Rd.Silv	20910 ver Spring

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2017 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** September 5, 2007 Gertrude Tuszynski 10:22 A M Eva /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Forest Hill 1 Colgate Drive 8. Date of Birth (Month, Day, Year)
Apr. 14, 1 Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2 💢 F Maryland 87 1920 Director 217-14-5622 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, it is Medical Eratic at mutal the collising at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Directo Forest Hill Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 Colgate Drive 21050 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Supervisor Department Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Johanna (nmn) Kilkowski Jacob (nmn) Tuszynski ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 662, Edgewood, Maryland 21040

Date 20c. Location - City or Town, State Regina Bolduc / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9-10-07 Dundalk, Maryland Sacred Heart of Jesus 4 □Donation 5 □ Other (Specify) 21. Signature of Theral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Colo-**Physician** 7e ar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available pnor to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home SAResidence 6 Other (Specify) 1 ☐ Yes 2 ☐ → 6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natoral 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completaly filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Testifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058475 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel 6025, Atreod Philip Nivetpm 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 2 2007 A SELISE Registrar

State Registrar 6)

32. Registrar's Signature

07-06767 Ruby Turner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 29232

al y	Turrer		For State Certificate of L		Reg. No.	2001 2520
	Physicia	n/ 1	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day	3. Time of Death Year 1436 hrs
P	্ব Examir	er	Ruby Turner	o. City, Town, or Location of Death	August 31, 2007	ity of Death
		4	4a. Facility Name (if not institution, give street and number) 4705 Norwood Ave	Baltimore	N/	
				if Under 1 Year If Under 24Hrs.		(YY) 9. Birthplace (State or
	Funeral Director		0.00001000011,11111	Months Days Hours Min.	10/01/1950	Foreign Country) Md.
	Director	L.	210 02 00.1	20	10/01/1000	
	any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits
	<u> </u>		Md. N/A Baltimore			1 X Yes 2 No
5	faryland 28a-f show 1 at once.	윉	10e. Street and Number	10f. Zip Code	. 10g. Citizen of	What Country?
-	hours after death with the Maryland matural", or items 23a or 28a-f she Ex miner must be notified at once	Director	4707 Norwood Avenue	21207	USA	
3	with the rate of the rate of		11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto		ace - American Indian, Black, Vhite, etc.
	r iten	Funeral	1 X Never Married 2 Married 1 Yes 2 X No	Yes 2 X No specify:	Spec	ity: Black
	after al", o	ρ	3 Wildowed 4 Divorced or Dates:	Yes 2 2 No specify: 's Usual Occupation (Give kind of w		of Business/Industry
	hours afte 'natural", Ex miner		during mo	ost of working life. DO NOT use retir	red) ·	and the second of the second o
	6 3	ompleted	Elollion del y Società y (1 - 1)	naker '.	Own	Home
	5-0036 led within 72 Hygiene. other than '	E I	12 Homer 17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maiden Suma	ame)
	21215-0036 Muld be filed within 7 Muntal Hygiene, marked other than c event, the Medic	Be C	Hungio B Turner	Florine	e Copeland	
	2121, nould be fill in marked itic event,	2	isa. Infoliation realisms (1)	Address (Street and Number or F		
	1 70 - 0		2010011	Somerset Stre	Date 20c. Locat	tion - City or Town, State
			20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition crematory or oth	ner place)		
	MOF Pages nent of ant: If or othe		4 Donation 5 Other Specify: Metro C	rematory 9/4	<u>4/2007 Balt</u>	imore, Md.
	Baltimore, permit. Pages I are Department of He Important: If ite injury or other tr	1	21. Signature of Faneral Service Licensee	tep Brothers of Facility tep Brothers 1 00 Eutaw Place	Funeral Hom	ne, PA 21217
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	he mode of dying, such as cardiac o	or respiratory arrest, shock, of	or heart Approximate Interval Between Onset and
V .	Physician Medical		failure. List only one cause on each line.	E .		Death
4	_xaminer		Immediate Cause (Final disease or condition resulting in death) a. Narcotic Intoxication Due to (or as a consequence of):	<u> </u>		
			Sequentially list conditions, b			
		iner		135.5		
		Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	760, icate be executed physician and the burial - transit	<u>=</u>	d			
	60, ate be executed obysician and be burial - transi	Medical	X UNPENDED AMENDED AMENDED, 27,28a-f, perME,g8	71, 9/27/07 TT	Lood D	ate of delivery
	760, icate be physic the bur	👸	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	etal death 3 Ectopic pregn		nth Day Year
	30x 687 death certific he attending of for use as t	cia	past 12 months? 1 Live birth 2 FG 4 Pregnant at time of death 5 0	ther (Specify)		
	Box 687 Re death certifice the attending of the ast t	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown		Did tabassa usa	contribute to the cause of death?
	Records, P.O. I The law requires that the icate has been signed by the page 2 should be detached	=		underlying cause given in Part I.		o 3 Probably 4 Unknown
	ires the signe	by by				24b. Were autopsy findings available
	ords v requ s been should	Completed			autopsy performed?	prior to completion of cause of death?
	ecc he lav ate ha	E E			1 ✓ Yes 2 No	1 Yes 2 No
	AL TR	O O	25. Was case referred to medical	26.Place of Death (Check		e 6 ✓ Other: Scene
	Vita nysicia this ce	To B	1 Yes 2 No		ing Home 5 Residence 28d. Describe how injury	
	of ing Pl After	=		1 Ves 2 V No	unk	
	ion ttendi death.	atio	Pending Investigation Fnd 8/31/2007 Fnd 2:3 Pending Investigation Fnd 8/31/2007 Fnd 2:3 Pending Investigation Pe	50 pm		Number or Rural Route Number, City
1	Division of Vital Records, P.O. Box 687 pinal or Attending Physician: The law requires that the death certific ours after death. After this certificate has been signed by the attending I filled in the the fineral director, page 2 should be deached for use as it	Certification:	3 Suicide 6 X Could not be determined (Specify) Fnd: residence	eet, factory, office building, oto.	or Town State)	ve Baltimore, MD
V				urred at the time, date and place, at	nd due to the cause(s) and fi	nanner as stated.
	To the Hos within 24 h To the Fur	<u> </u> <u> </u>	Certifying Physician: To the best of my knowledge, dearn occ (Check only one) 2 Medical Examiner: On the basis of examination and/or investig	ation, in my opinion, death occurred	d at the time, date and place	, and due to the cause(s)
	To the I within 2 To the I	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Da	te signed (Month, Day, Year)
		-	Wayinte Me Virele	O.C.M.E.	Septe	ember 1, 2007
	i Pir		30. Name and address of person who completed cause of death (Item 23a)			
10	10		Margarita Korell MD. Assistant Medical Examiner 111	Penn Street, Baltimore, MI	D 21201	
		State	e 31. Date filed (Month, Day, Year) 32. Registrar's Signature	and a		OCME
	Dog	etra	TELLICION INSCRIPTION OF A STATE OF THE PROPERTY OF THE PROPER			

		-	For State Registrar	State of Maryland		artment of Hortificate of L			ene 9. N° 2 8	07	20222
Phy	sicia	n	1. Decedent's Name (First, Middle, Last) HATTIE BROWN	TURNER				2. Date of Death Month Septemb			9:15A M
	edica ımine		4a. Facility Name (If not institution, give str Gilchrist Center			4b. City, Town, or Towson	Location of Deat		4c. County		
Fune Direc		L		7. Age (In yrs. I.	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		1916	Coun:	ace (State or Foreign try) 1nia
e Maryland 3a-f show	mileo at	_ [Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		, Town or Lo	cation					0d. Inside City Limits 1 ☐ Yes 2 ☐ No
with th	an in	II Dire	10e. Street and Number 531 Stevenson Lane			10f. Zip Code 21286	5	10	g. Citizen of	What Coun	try?
at yidilid XIXI35-UU30 Should be filed within 72 hours after death with the Maryland and Mental Hygiene. In anked other than "natural", or items 23a or 28a-f show maric soon the Medical Exemination must be notified at		by Funera		2. Was Decedent Ever in U.\$ Armed Forces? 1 □ Yes 12 □ No If Yes, Give Year or Dates:	1	Vas Decedent of His f Yes, specify Cubar □ Yes XX No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Rad Bla	ce - America ck, White, e fy: Bla	etc.
within 72 houelene. than "nature he Medical E		Completed	15. Decedent's Educa (Specify only highest grade of	ation completed) College (1-4or 5+)	(Give life. L	lent's Usual Occupa kind of work done di 20 NOT use retired) NESTIC	tion uring most of wo	rking	6b. Kind of B	usiness/Ind	·
Laryland ZIZ 2 should be filed within and Mental Hygiene. is marked other than an animatic event the Market th		õ	17. Father's Name (<i>First, Middle, Last</i>) Unknown				Unk	ne (First, Middle, Mi	aiden Surnar	me)	
and 2 sho ealth and n 27 is m			19a. Informant's Name/Relationship (Type Judith G Dobson	e. Print) POA				imore, Ma			
parimition 4, Initial yiland AIX 15-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any interest to the training to show the training to another training to another training to another training to another training to another training to another training to another training to another training to another training to a second training and the profit of the p	once,		20a. Method of Disposition 1 Burial ACcremation 3 Rer 4 Donation 5 Other (Specify) 21. Inature of Funeral Servi Licensee	ure	ace of Disposemetery, crem	sition (Name of natory or other place It Cremato	e) 0ry 9/8 s of Facility650	Date 29	Baltimore	ore, • MD 21	wn, State Maryland 212
Physici /Medio Examir	cal ner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death cause on each line. Due to (or as a consequ	ence of):	er the mode of dying	-	c or respiratory arres	st,		Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director made 2 should be detached for use as the hurial strangilland.		Cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ							
ires that the death certisions ago by the attending the defacted for use a		Pnysician/iwed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)				ate of delive	ry Day Year
w requires that been signed be detailed.		2	Part II. Other significant conditions contri	ibuting to death but not resu	Iting in the un	derlying cause give	n in Part I.	23e. Did toba		tribute to th	e cause of death? ably 4 ∐Unknown
ding Physician: The law re h. After this certificate has be funeral director, page 2 shr		Completed						24a. Was an autopsy perform 1∐ Yes 2	de	prior to con death?	osy findings available apletion of cause of
ysiciar is certif		o De	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	spital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	Other		ath <i>Check onl one</i> Jome 5 Residen	ce 6 20 Oth	ner (Specify	Masoice
ending Ph ath. or: After th			27. Manner of Death 1 Natura! 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work? M 1 \(\supers	at	28d. Describe how			, had to
ital or Attencurs after death		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hor building, etc. (Specify)			28f. Location (Stre City or Town,	State)		<u> </u>
To the Hospital or within 24 hours afte To the Funeral Discompletely filled in		Medical	29a. Certifier Certifying Physic (Check only one) 2 ☐ Medical Examine	cian: To the best of my knover: On the basis of examination and manner stated.	vledge, death ion and/or inv	occurred at the time restigation, in my op	e, date and place inion, death occu	e, and due to the cau urred at the time, dat	ise(s) and m te and place,	anner as sta and due to	ated. the cause(s)
To the within To the		M	29b. Signature and title of certifier	~		29c. License	number 5830	3 5	Date signer eptw	nd (Month, I	Day, Year) 7 2007
3			30. Name and address of person who com	pleted cause of death (Item	23a) (Type, F	Ol A)	Charle	3 S	NSIN	mo	21204
Rec	State	3 7	31. Date filed (Month, Day, Year) SEP 1 2 2007	32. Registrar's Signat	ure	Se de la companya della					

DHMH 17 Rev 1/2001

9:15 MM

Turner, Hattie

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygien 2007

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sent **Physician** 2007 7:30 AM Darlene 5 Wilson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

April 28,1964 Birthplace (State or Foreign Country)
 Mary Kand 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F 218-86-1114 Yrs. Director Usual Residence of Decedent 10b County 10c. City, Town or Location 10a State 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Michigal Execution into the notified at Baltimore MD 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2519 E. Madison Street 21205 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1□Yes 2XNo Btack Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Envonmental Service Environmenta Service Assistant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mental is marked o William S. Wilson Lorraine J. Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JacquelineRenee Blair 2519 E. Madison St. Balto. md 21205 item 27 i 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. Sept 132007 Catensville Maryland Crematory Metro 22. Name and Address of Facility
Rended a Dicy on Funeral Service
276 Fred Helton Pass Balton Md 212 21. Signature of Funeral Service Licenses 9 Graysor Romard 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERKALEMIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner RENAL INSUFFICIENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2No 3 Probably 4 Unknown 1 TYes this certificate has been siral director, page 2 should I 24a. Was an autopsy performed? 1 ☐ Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Tyes : After this certification of the formula director, p 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation i or Attend after death Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital of within 24 hours at To the Funeral D. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier D31136 KICBRODE LA STOT MORE MA 21236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The second of the second of State 2007 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan		rtment of H tificate of L			°2007	29236
В	Physici		1. Decedent's Name (First, Middle, Last)	e w	ilsur	1		2. Date of Death Month	Day Year	3. Time of Death 425 AM
	/Medio Examir		4a. Facility Name (If not institution, give s	treet and number)	1300	4b. City, Town, or	Location of De	ath	4c. County of Deat	1
	Funeral Director		410-54-5853			If Under 1 Year Months Days	If Under 24 H	in. (Month, Day,	Year) 9. Birt Co 3, 1934	(hplace (State or Foreign untry) TN
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	8a-fst	ector	MD Carr	oll	Mt. A	7				1 ☐ Yes 2 🙀 No
	3a or 2	i Dir	10e. Street and Number 12892 Colonial	Drive		10f. Zip Code 2177	71	10	g. Citizen of What Co United St	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked othar than "natural", or Items 23a or 28a-f show othar tranmatic avent. Ite Medical Ection at include Lericalities at othar tranmatic avent. Ite Medical Ection at include Lericalities at	by Funeral Director	11. Marital Status 1 Never Married 2XXMarried 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 XX0 o If Yes, Give Year or Dates:	11	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	rican Indian,
15-0	"natur	eted	15. Decedent's Educ (Specify only highest grade	eation completed)	(Give	ent's Usual Occupa kind of work done of OO NOT use retired	during most of v	vorking 1	6b. Kind of Business/	
21215-0036	d withir giene. ar than	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)			BI		Federal	Gov.
and	should be filed with nd Mental Hygiene. markad othar thar umatic avent.	Be	17. Father's Name (First, Middle, Last) Jerome Robb.	inc				lame (First, Middle, M		
Maryland	2 should and Me Is mark raumatic	To.	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street a		nima D Rural Route Number,	Uncan City or Town, State, 2	Zip Code)
	1 and 2 Health Iem 27 I		William F. Wilson 20a, Method of Disposition		_	892 Color	nial Dr		iry, MD Oc. Location - City or	21771
mor	Pages nent of I int: If its		1 ØBurial 2 ☐ Cremation 3 ☐ R	emoval from State	emetery, cren	natory or other plac Cemetery		ot. 15, 20		
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or otha <u>once</u> .		21. Signal re of Funeral Service Liegnse	ally	22 B1	Name and Address Urrier-Ou 212 W. Ol	ss of Facility 1een Fui ld Libet	neral Home rty Road W	& Cremato infield. M	PA D 21784
			23a art . Enter the disease, or complish shock, or heart failure. List only on	e cause on each line.	n. Do not ente	er the mode of dyin	g, such as card	iac or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ		uscula	1 MC	cecins		
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dus.	acuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
8760,5	icate be executed physician and s the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a consequ	ience of):					
Вох 68	eath certif attending for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past \(2 \) months? 1 \(\text{Yes} \) Yes	ac. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	-		23d. Date of del Month	ivery Day Year
P.0	at the did by the letached	Phys	9 Unknown Part II. Other significant conditions con	9□ Unknown	ultina in the co	alashian anyon ay	on in Dant I	220 Did tob	acco use contribute to	the sauce of death?
rds,	quires that n signed b	þ	Brain to		to Gov		in Paris.		s 2 No 3 Pr	C_
Records,	law requir las been si s 2 should	Completed						24a. Was an	prior to o	stopsy findings available completion of cause of
			25. Was case referred to medical				00 81 5	perform 1 Yes 2	Na 1□Yes	3×2 No
of Vit	<u>> .∞</u> ¬	To Be	examiner?	ospital: 1 Inpatient 2 I	ER/Outpatient	3 □ DOA Othe	ar Les	eath <i>(Check only dne</i> Home 5 Resider		cify)
	ding P th. After t funera		27. Manner of Ceath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	yat (? Yes 2 □ No	28d. Describe how	w injury occurred	
	al or Attending after death. I Diractor: After d in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre			28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital or Attending Ph within 24 hours atten death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Physical Check only one) Medical Examin	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the timestigation, in my op	ne, date and pla pinion, death oc	ace, and due to the ca accurred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
1	To t withi To tll	×	29b. Signature and title of certifier		Ø	29c. License			d. Date signed (Monti	
,	Q		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, I	Print)	15942	5 3	September	10,2007
)		Ndich Feinberg, n	(D) (D) (D)	Daybre.	ak Cirile	but !	4150-236	Clarks ville,	MD 21029
	Sta Registr		SEP 1 2 200	32. Registrar's Signat	ui e	Carl Contract				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 5:22 A M Katherine Weller September 9,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center Rosedale Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV. 28, 1913 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1 □ M 2X F 213 03 3609 93 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified Maryland Baltimore 1 ☐ Yes 2 No Director Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or 1813 Old Eastern Avenue 21221 USA Funeral Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items; it may injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 ₩ Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Payroll Clerk Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur L. Tellis Margaret Ritter ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Phelps (Niece) 13 Topwood Ct. Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 SpBurial 2 □ Cremation 3 □ Removal from State 9/12/2007 4 Donation 5 Dother (Specify) Most Holy Redeemer Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature 6 Funeral Service L 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ea /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-trai Box 68760, Due to (or as a consequence of): attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔀 No 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9☐Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe 2 X No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 X Natural 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

ours after death.

neral Director: A
filled in by the fu To the Hospital o within 24 hours aff To the Funeral Di completely filled in

> State Registrar

31. Date filed (Month, Day, Year) 12

29b. Signature and title of certifier

0 32. Registrar's Signature

30. Name and address of person who completed chuse of death (Item 23a) (Type, Print)

John

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPT 9,2007 Stuart A. Wild **Physician** 4:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept II, 1915 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Mass Yrs 91 022 09 3087 Director Usual Residence of Decedent 10d. Inside City Limits
1 ☐ Yes 2 ☐ No 10c. City, Town or Location 10b. County r 28a-f show notified at Temple Hills Maryland | Prince George Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 piny or other traumatic event, the Medical Examiner must be anone. United States 20748 6722 Berkshire Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1**X** Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes y2√☐ No Specify. Specify: White à ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government LIthograver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Kean Anton A. Wild ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Donald Noble (Per Rep) 7801 Old Branch Ave, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept 13. 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 2007 Newton Center, Mass 4 ☐ Donation 5 ☐ Other (Specify) Newton Cemetery 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service I Alexandria Ferry Road, Clinton, MD 20735 m00251 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration

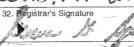
Due to (or as a consequence of): precinouta **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and is the burial-trans resulting in death) Last Due to (or as a consequence of): O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown in the past 12 months? Month Day Vear 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown Leukocybic Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ♣ No 24a. Was an autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

bol Post OFFICE RUAD; 1-4 31. Date filed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



WALDORF, MARYLAND 2060 Z

HB H0042445

September 9,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#28b perMF C871 9/12/07 WS
State of Maryland 7 Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day September **Physician** 1550P M George Watsor 2007 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MIVERSIY Medical Ctr salt more Maryland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | APR . 27, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ F 225 32 7225 77 VIRGINIA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 28a-f show at 1 ☐ Yes 2 ☐ No notified Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ō ber 21213 USA 2700 N. CHARLES ST. 23a traumatic event, the Medical Examiner must Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? or items 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CRANE OPERATOR BETHLEHEM STEEL CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be HERBERT WATSON NANNIE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau 4525 SHAMROCK AVE. BALTO, MD. 21206 JOSEPH WATSON (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Ponation 5 □ Other (Specify) SEPT.15,2007 ANNE ARUMBEL CO. CEDAR HILL CEM. 21. Sy ature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician my cutinus 18 Chemic Sdays /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last EXAMINER Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL burial-transit and Due to (or as a consequence of) Box 68760, physician pe Physician/Medical the for use as attending (F FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 □ Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autonsy performs 2 **1** No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. F. 25. Was case referred to medical examiner?
1 X Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Datural 5 ☐ Pending investigation 9/6/07 1 ☐ Yes 2 ☑ No Fall 2 Accident 3 Suicide Unk. 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide MUSING NOME

2700 N. Charlus St. Balto MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10,2007 Ptember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 South Street Veatts aviene 82. Registrar's Signature 31. Date filed (Month, Day 2 2007 State 13061 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 4:39 р м Gloria H. Weiss 04 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Montgomery Bethesda | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | 1-29-1917 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 N F 116-09-3639 90 Director New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No Chevy Chase Director Montgomery MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3312 Brooklawn Terrace USA 20815 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Private/Handwriting Elementary/Secondary (0-12) College (1-4or 5+) Graphologist Expert 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Zuckerman Emanuel Hacker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lynn Weiss/daughter 8630 Geren Rd. Silver Spring, MD 20901 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Beltsville, MD 9-8-2007 Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Crem.Sv.933 Gist Av.Silver Spring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Clostridium Difficile Colitis Sequentially list conditions, if any, leading to turnediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner and that initiated event resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. ð Renal Failure 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Pulmonary Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform neral Director: After this certificate filled in by the funeral director, pag 2 N No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Far er death. 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours are to To the Funeral Direc 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifi D0063195 9-6-07 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) 20 S. Wilks Suburban Hospital 8600 Old Georgetown Rd. Bethesda, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 1 2 2007 Registrar

DHMH 17 Rev 1/2001

September 4,200

Neiss, Gloria

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 8,20078:30 P.M **Physician** Lillian F. Wiegand /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Riverview Nursing Home Essex Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State Months Days Hours Min. | Sept 11, 1923 | Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 √ F 218-12-8393 83 Director Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show notified at 1 ☐Yes 2 ☐ No Md. Director n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. p e 155 Grundy Street Apt. 206 21224 U.S.A. ral", or items 23a Examiner must b Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 A Divorced White the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant s marked other tumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lepartment of Health and Ment, Important: If item 27 is marked any Injury or other traumatic evonce. Robert Fryer Sarah O'Neill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon Wiegand (son) 8342 Amity Circle Gaithersburg, Md 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery9-11-2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disettle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit physician the burial Physician/Medical attending p for use as 1 IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 1as certificate ha funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director: completely filled in by the f To the Hospital

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

Savinder K.

SEP 1 2 2007

29b. Signature and title of certifier

(Check only one)

Julka, M.D. 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Market Place Baltimore, Maryland 21222

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

27188

29d. Date signed (Month, Day, Year)

September 10, 2007

Physician /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Funeral

Director

28a-f show

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9

permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other th any injury or other traumatic event, the once.

Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical

Director: within 24 hours at To the Funeral C completely filled i

6 ☐ Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Ercertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

064395

29d. Date signed (Month, Day, Year)

SEPTEMBER 10, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIENE DOBERMAN, MD 6565 N CHARLES ST. SUITE 214 BALTIMORE, MD 21204

31. Date filed (Month, Day, Year) SEP 1 2 2007 State Registrar

32. Registrar's Signature

		1 - For State Registrar	State of Ma	arylan	d / Depa	artment of I	Health	and Me	ental Hy			29243
Physicia /Medic Examin	al	1. Decedent's Name (First, Midd Tuan) ta 4a. Facility Name (If not institution Washing ton	Wooten	Har	oital	4b. City, Town,	or Location		2. Date of De Month	Olo	Year 2001 County of Dea	7 18:34 PM
Funeral Director		5. Social Security Number 579–62–3169 Usual Residence of Decedent	6. Sex 7. Age	e (In yrs. i	ast birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. s Min.	8. Date of Bir (Month, Da December	th 194 ly, Year) er 12	6 9.481	unplace (State or Foreign Sountry)
farylan ebow	ō	10a. State 10b. County Maryland Prince			, Town or Lo							10d. Inside City Limits 10d. Yes 2 □ No
h with the h	Funeral Director	10e. Street and Number 1317 Merrimac		пуац	CSVII	10f. Zip Code 20912	2				en of What C	Country?
S	þ	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give Year or Dates:			Was Decedent of I If Yes, specify Cub	Speci	can, Puerto R	erfy Yes or No ican, etc.)		Black, Wh	lack
21215- od within 72 glene. or than *na or than *na	Completed	(Specify only higher Elementary/Secondary (0-12) Eleventh	nt's Education sst grade completed) College (1-4or 5	+)	(Give life.	dent's Usual Occui kind of work done DO NOT use retire	during m	ost of working	g	Geor	d of Business ge Was versity	shington
tal H d oth	Be	17. Father's Name (First, Middle, Francis Jones	Last)					ther's Name (ivia W :			Sumame)	
aryla 2 should and Men 1s marks	၉	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street	1			-	Town, State,	Zip Code)
d a se		David Wood/Son 20a. Method of Disposition 1 Burial 2 Cremation		CE	lace of Dispo emetery, crei	Good Hop esition (Name of matory or other pla	сө)	Septer	ber	20c. Loc	ation - City o	r Town, State
Baltimore, permit. Pages 1 a Department of Hee Important: If tem any injury or othe		4 Donation 5 Other (S		Пал	22	Memorial 2. Name and Addre 61 Good 1	ss of Fac	ality Robe	ert G.	Masc	n Fune	Maryland Eral Home Inc 2020
176(ilcal Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Soundley list on the first and list a	b. Due to (or as a d. Due to (or a) d. Due to (or a)	a conseque	Average of): Strice of):	tery I Gan	514e	ase				Approximate Interval Between Onset and Death
Geath cert death cert eath of for use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal	death 3	Ectopic pregnanc Other (specify)	у	TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO 10 TO		23	3d. Date of de Month	olivery Day Year
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Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pendir investi could determ	gation not be 230 Stoop of Injur	Year)	28b. Time of Injury me, farm, str	M 1	y at		id. Describe I	now injury	occurred	tural Route Number,
To the Hospite within 24 hours To the Funeral completely filler	edicai	one)	ng Physician: To the best of Examiner: On the basis of and manner sta	examinati	vledge, death	vestigation, in my c	pinion, di	eath occurred	at the time,	date and p	place, and du	e to the cause(s)
with To T	Σ	29b. Signature and title of certifie	ite			29c. Licens						th, Day, Year)
2		30. Name and address of parson	who completed cause of de	eath (Item	23a) (Type,	Print)	208 7)	32 1a Par)		60	T
Stat Registra		31. Date filed (Month, Day, Year)	Th +600 32 Registra 2007	CAY ur's Signati		Ave la	Kom	a far	K, [1]	D		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ELIZABETH 09 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS HOSPITAL BALTIMORE JOHN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 F 92 Yrs. 212-12-6885 **Director** Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County tems 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f shov matic event, the Medical Examiner must be notified at ¥Yes 2 No BALTIMORE Director MD 10e. Street and Number 10g. Citizen of What Country? 21205 U.S.A. E. MONUMENT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 □ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ BLACK 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE Aide NURSES 12tharade NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If Item 27 is marked o Laura 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. YANCEY/DAUGHTER E. MONUMENT ST. BALTO, MD. 21205 OYCE 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING PARK CEMETELY 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 9/10/07 BALTIMURE, MD 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN Greene Funeral Scr P.A. M01363 4905 YORK ROAD . BALTIMORE, MD. 21212 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Part1. Inter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-trans Due to (or as a consequence of): Jivision or Vital Records, P.O. Box 68760. Completed by Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an s certificate has b lirector, page 2 s autopsy 2 No 1□ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 😿 No 2 ER/Outpatient 2 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and ress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Signature

State of Maryland / Department of Health and Mental Hygiene 20 29245 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Allen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Rawlings Allegany 15814 Meadowdale Drive. SW If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Apr 5, 1923 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Country) Hours Min. 1 ☐ M 2 🙀 F Director 185-22-7509 84 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at Allegany Rawlings MD 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21557 15814 Meadowdale Drive, SW USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify þ Specify: 3 X Widowed 4 □ Divorced white "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the M Elementary/Secondary (0-12) College (1-4or 5+) Willow Valley Apts. Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearl (Dillinger) Silvis Marvin Silvis ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
45244 Maadawdale Dr Rawlings MD 21557 19a. Informant's Name/Relationship (Type. Print) Bonnie Bean daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Date 20c. Location - City or Town, State permit. Pages Department of I Important: If its any injury or o 1 → Burial 2 □ Cremation 3 □ Removal from State Restlawn Memorial Gardens 9/6/2007 MD LaVale 4 ☐ Donation → 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a arr. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, scok, or heart failure. List only one cause or a schline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a cons duence of) Examiner Sequentially list conditions, it my leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown s been signed be should be deta to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatur and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) 3 MBERLAM WD 21203 ALKINS, M 32. Registrar's Signature 3 500 MEM State Registrar

2. Date of Death

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onse and Death

64145

Year

Yes 2 No

Maryland

Black, White, etc.

Month

Day

3 ☐ Probably 4 ☐ Unknown

White

P.M

For State Registrar

Physician

1 Decedent's Name (First Middle Last)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1 1 2007

Grade)

32 Registrar's Signature

07-06752 Kevin R. Brandly Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

vin R. Brandly		For State	laryland / Departme <i>Certifica</i>	ate of Death	u Mentai i i	Reg. I	No. 20	07 29	321		
Physiciar	1/ 1	Decedent's Name (First, Middle,Last)				2. Date of Death Month Da August 31, 2	ay Year	3. Time of Death 0043 hrs			
edical Examin		Kevin R. Brandly a, Facility Name (if not institution, give street		4b. City, Town, or	Location of Death		4c. County of Deat	h			
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th the Maryland 23a or 28a-f sho notified at once	Director	6913 Perry Woo	od Rd.	2077	2		U.S.A.				
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leath v	Funeral	1 XNever Married 2 Married	Armed Forces? Yes 2 XNo	If Yes, specify Cuba		Rican, etc.)	В	lack			
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Baltimore, permit Pages I am Department of Hear Important: If iten injury or other tra		1 A Burial 2 Cremation 3 R	cremat	tory or other place)	Q /	6/07	Clinton	n,MD			
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Ball permi Depar Impor	1	21, Signature of Funeral Service Licensee	ward.	6500 All	entown	Rd. Cam	p Sprin	gs, MD 2	207		
Physician	Ť	23a. Part I. Enter the disease, or complicati	ons that caused the death. Do n	ot enter the mode of dying	g, such as cardiac	or respiratory arres	t, shock, or heart	Approximate In Between Onse			
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60, ate be hysici e buria	led Med	IF FEMALE: 2	3c. If yes, outcome of pregnancy		0/ 11		23d. Date of deliv				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi	ပ	29a Certifier	To the heat of my knowledge d	leath occurred at the time	, date and place, a	and due to the caus	e(s) and manner as	stated.			
To the J within 2 To the J	Medical	an an	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
FSFS	Me	29b. Signature and title of certifier	1	ense number		August 31, 20					
			MD	-11	C.M.E. 						
6.10		30. Name and address of person who com Ling Li, MD Assistant Med		n) nn Street, Baltimor	e, MD 21201						
01		31. Date filed (Month, Day Year)	32. Registrar's Signatur								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7 ay 2<u>007</u> **Physician** Month August 17, 7:39 ДМ Evelyn L. Buracker /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolls

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of North) | Sept. 23, 1932 | Washington, DC Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕸 Director 577-42-9274 74 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show r than "natural" or Items 23a or 28a-f shor the Medical Examiner must be notified at 1 X Yes 2 ☐ No Directo Maryland Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiliset must once. USA 21054 1387 Defense Highway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 □ Yes 2 □XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Safeway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Peters Christopher Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6019 43rd Street Hyattsville, MD 20781 Wesley Catron/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 8/21/2007 Brentwood, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Robert E. Evans Funeral Home <-16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 10ais /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedant pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Deetat death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Cereinovascular accident Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No rector, page 2 st 24a. Was an autopsy performed? Yes 2.0 N 1 🗆 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only of Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient Inpatient 3 DOA 27. Manner of Death 1. Prinatural 2 ☐ Accident Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending n 24 hours after death.

The Funeral Director: After the function of the funct 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) canive wer mo DS2830 30. Name and address of person who completed cause of death (them 23a) (Type, Print)

JEANINE WEINER MD, 900 Bestgate Road #30, Map 115, MD 2144

31. Date filed (Month, Day, Year)

AUG 2 4. 2007 31. Date filed (Month, Day, Year) AUG 2 4. 2007 State Registrar

Physician

/Medical

Director

Funeral

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Physician/Medical

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Certification: To

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Martin Weltz

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2007 19, 5:45 P^{M} August Clarissa Minthorne Beall 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 3P Research Road Greenbelt If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min. Months Days Hours 1 □ M 2**X** □ F 220-48-3882 54 29, 1953 Washington, DC Apr. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Greenbelt Maryland Prince Georges 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 3P Research Road 20770 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Psychometrist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Elizabeth Byers Otho Thompson Beall, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claiborne B. Beall/ Brother 1408 Medinah Court Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory prother place) Metropolitan Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8/22/2007 Alexandria, VA 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee Auc 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Glioblastoma Multiforme Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2**X** No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 X No 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Delletzun D23743 August 20, 2007

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) AUG 2 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525 Greenway Center Drive Greenbelt, MD 20770

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State of Maryland / Department of Health and Mental H	l ygiene	
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Physici		1. Decedent's Name (First, Middle, Last) Mildred Beall	2. Date of Death Month August 2	2007	3. Time of Death 0520 AM					
/Medic			b. City, Town, or Location of Deat		25 2007 0520 AM 4c. County of Death					
Funeral Director			Glew Burnse If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	Hunt MR y) 9. Birthy Cou	place (State or Foreign				
yland now at	tor	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel 10c. City, Town or Loca Glen Burn			1	10d. Inside City Limits 1 ☐ Yes ŽŽNo				
	Funeral Director	10e. Street and Number 835 North Shore DR.	10f. Zip Code 21060	10g. C	Citizen of What Coul	ntry?				
	by	Armed Forces? If Y	s Decedent of Hispanic Origin? (\$ res, specify Cuban, Mexican, Puer]Yes 2⊠ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: White	etc.				
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Hygiei ther th	S	17. Father's Name (First, Middle, Last)		me (First, Middle, Maide	School Sy en Surname)	stem				
fental rked o	To Be	Robert Denton Robert Denton	Unis B		ŕ					
alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Thomas Beall Son 19b. Mailing 835 No	Address (Street and Number or R rth Shore Dr.	tural Route Number, City Glen Burnie						
rtment of He rtant: If item		1 □ Bunal 245 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crem	tory or other place)	7/2007 Bal	Location - City or To Ltimore, M	1D				
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Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, last each cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of):	VASCU) On ACCI			Approximate Interval Between Onset and Death				
g physician and as the burial-transit	dical	resulting in death) Last Due to (or as a consequence of): d.								
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been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to t	the cause of death? bably 4 □Unknown				
sician: The law red certificate has bee irector, page 2 shou	Completed			24a. Was an autopsy performed'	prior to co death?	opsy findings available ompletion of cause of				
is certific director,	o Be (25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatient	Other:	eath (Check only one)	S Dother (Coope	1.30				
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n 24 hours ne Funera	Medical C	29a. Certifier (Check only one) **Certifying Physician: To the best of my knowledge, death of the best of my knowledge, death of any knowledge, death of the best of my knowledge, death of the best of my knowledge, death of any knowledge, death of the best of m								
withis To the comp) M	29b. Signature and title of certifier Hey Two M 30. Name and address of person who completed cause of death (Item 23a) (Type, Property of the complete of th	29c. License number D027413	5 Au	Date signed (Month, 9 w $7 35$,	, Day, Year) 入い子				
D		30. Name and address of person who completed cause of death (Item 23a) (Type, Prince of the Complete Cause of Da Hinarc	WAShirston M	redical Ga	enter					
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Figistrar's Signature	ode							
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			For State Registrar	State o	f Marylan		artmen rtificat			and M		leg. No. 2	007	2925	
	Physicia /Medic	an		Decedent's Name (First, Middle, Last) Theodore G. Bloom						2. Date of Dea Montin 8 /	th 2 <i>5</i> %200	7 Year	3. Time of Death	M	
	Examin	- 4		titution, give street and number)				4b. City, Town, or Location of Death Annapolis					County of Death Anne Arundel		
e .	Funeral Director		5. Social Security Number 244–28–6302	6. Sex XX M 2□ F	7. Age (In yrs. 8		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth 07/18/1	926	9. Birthpl Count	ace (State or Fore	ign
	show d at	_	Usual Residence of Decedent 10a. State 10b. Coun MD Anne	y Arundel		ty, Town or Lo							10	0d. Inside City Lim	
	h the M r 28a-f r notifie	Funeral Director	10e. Street and Number			<u> </u>	10f. Zip	Code			1	I0g. Citizen of	What Coun	try?	
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 □ Never Married ※※ Ma 3 □ Widowed 4 □ Divorce	Armed Fo	2□ No Ko:	rea 🗀	was Dece If Yes, spe		spanic On n, Mexicar Specify:	gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)	Spec	ack, White, e	etc.	
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	should be filed nd Mental Hygi marked other imatic event, ti	To Be Co	17. Father's Name (First, Middle Jack Bloom	e, Last)			<u> </u>				e (First, Middle, Stern	Maiden Surna	ame)		
lary	2 should hand his ma		19a. Informant's Name/Relatio			1	_				al Route Numbe	-	n, State, Zip	Code)	
	thealth Health tem 27 other t		Mary Louise 20a. Method of Disposition	Bloom Wi		312 Place of Dispo cemetery, cre	Halse	-			olis, MD Date	20c. Location	- City or To	wn, State	
altimore,	Pages nent of l ant: If its ury or o	715	1 ☐ Burial ※ACremation 4 ☐ Donation 5 ☐ Other		State	tro Cr	emato	ry			7/2007	Balti			
Balt	permit. Departr Importa any Inji		21. Signature of Funeral Sent	ce Licensee							desty F napolis,			P.A.	
	Physician		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition	or complications that is only one cause on	caused the deat each line.	th. Do not en		_			or respiratory arı	rest,		Approximate Interval Between Onset and Death	
1	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):		0	,	2 4					
31		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to financial cause. Enter Underlying													
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89	lificate t g physions as the b	edical	H. Comment	d					-						
O. Box	Attending Physician: The law requires that the death certificate be executed releath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	itcome pf pregn birth 2 □ Feta nant at time of d nown	al death 3[⊒Ectopic p ⊒ Other (s _i						ate of delive Month	ry Day Year	
S, D	uires that tl signed by Id be detac	by	Tata. Other significant contained contained to death but not recentling in the under-									Did tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
Record The law require the has been sight 2 should be	The law rec ate has beer bage 2 shou	Completed									24a. Was a autop perfor		prior to cor death?	psy findings availa npletion of cause o	ble of
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n or	ding Phys h. After this funeral dir	on: To	1 res 2 ivo 1 inpatient 2 EH/Outpa					of 28c. Injury at Work?			Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				_
Division or	for Attendafter death. Director: A	Certification:	3 Suicide 6 □ Cou	rmined 200. Flat	not be ago Place of injury. At home farm street factory office			Yes 2	es 2 No 28f. Location (Street and Number or Rural Route City or Town, State)			l Route Number,			
	Hospital 4 hours a Funeral tely filled	edical Ce		ying Physician: To the last Examiner: On the land man											
	To the within 2 To the complet	Me	29b. Signature and title of certi	-1	•				e number		1	29d. Date sign	/	-	
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	1,0/0		30. Name and address of pers	(1) S , W(1)	900 B	37 3 67	Le K	15	tes	300	iAnna,	polis	mo	21401	
	Sta Regist		31. Date filed (Month, Day, Ye AUG 2	7 2007 ³²	egistrar's Sign	ature	book	,			(Anna)				

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

Kobert

31. Date filed (Month, Day, Year, AUG 2 0 2007

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Norma 200 Byris L. Huaust /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** lemoria tospita aston If Under 24 Hrs 9. Birthplace (State or Foreign Country) Maryland If Under 1 8. Date of Birth (Month, Day, Year) 10-28-1940 7. Age (In yrs. last birthday) Year **Funeral** Months Days Min. 1 □ M 2 🕱 F Yrs 66 Director 219-36-5721 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director Caroline Md. Ridgely 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or edical Examiner must be r 11990 Central Ave. 21660 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 2 2 No 21215-0036 1 ☐ Yes Specify. Specify Completed by 3 Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Worker Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be 27 is marked or traumatic ev Samuel Boyce Mary Lee Carter ဂ္ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrica Ann Warner P.O.Box 233, Ridgely, Maryland 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o once, 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 DOther (Specify) Corkers Cemetery 08-25-07 Greensboro, Md. 22. Name and Address of Facility
Bennie Smith Funeral Home 21. Sinnature of Funeral Service Licenses 678 426 Dover St. Easton, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4 NOXIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unes a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ed by the detached 1 ☐ Yes 2 No 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably → Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy performed? The certificate 2UN or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 254 No 1 Tes ↑ Impatient 2 ER/Outpatient 3 DOA 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident neral Director; / 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a

To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier N 2007 1)005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date fil

M.D., 219 S. Washington St. Easton, Md. 21601

Dennis Deshields IVI Dennis Deshields 2. Registrar's Signature

2 2 2007

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 2 physician this After death. after death in by To the Hospital within 24 hours at To the Funeral C filled i

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

29b. Sig

e and title of certifier

31. Date filed (Month, Day, Year)

Drn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

251

32 Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	nate of maryland	Certi	ficate of	Death	Reg	N2007	29255
Ą.	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	/Medic	al	Leroy Ca 4a. Facility Name (If not institution, give stre	mpbell eet and number)		4b. City, Town, o	r Location of Death	Hugust	22 2007 4c. County of Death	1020 M
	Examin	ei e	Peninsula Regional	Medical Co	MU		usburg	,	Hilon	1/0
	Funeral Director		5. Social Security Number 6. Sex 1215-26-3925	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 07/07/28	(ear) Cour	lace (State or Foreign htry) Land
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	tion			1	0d. Inside City Limits
	a-f sh	ctor	Md. Wicomico	Fr	uitland	1				1 Yes 2 No
	vith the	Funeral Director	10e. Street and Number			10f. Zip Code		10g	J. Citizen of What Cour	ntry?
	leath v	eral	605 Allen Road 11. Marital Status 12.	Was Decedent Ever in U.S Armed Forces?	5. 13. Wa	2182 as Decedent of H	6 dispanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No-	U.S.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armer Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		Yes, specify Cub		Rican, etc.)	Black, White, Specify: W	etc. nite
15-0	"natur	letec	15. Decedent's Educat (Specify only highest grade c	ion ompleted)	16a. Deceder	nt's Usual Occup nd of work done NOT use retired	oation during most of work d)	ing 16	6b. Kind of Business/In	dustry
121	withir iene. than the Me	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+) none		eafood D			Seafood	
	al Hyg I other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma	•	
Maryland	2 should be f n and Mental h Is marked of raumatic evel	2	John Campbell	D-i-A\	10h Mailing	Address (Ctrast		e Bratto	n City or Town, State, Zip	Cadal
Mai	and 2 st ealth and n 27 Is n		19a. Informant's Name/Relationship (Type. Brian Campbell/Son	Printi	1	•	ad, Fruit			(Code)
Jre,	ss 1 ar of Hea item		20a. Method of Disposition 1 Burial 2 Cremation 3 Rem	20b. Pla		tion (Name of atory or other place	ce)	Date 20	Oc. Location - City or To	own, State
Baltimore,	Pages Iment of I Iant: If ite jury or of		4 ☐ Donation 5 ☐ Other (Specify)	Spr		L Memory	Garden	/25/07	Hebron, Mo	1.
Ball	permit. Departr Importa any Inj		21. Signature of Funeral Service Licensee	. 1		Name and Addre	· 1		neral Home s Anne, Md	21052
	Physician /Medical Examiner		23a. Paper. Enter the disease, or complications, or heart failure. List only one Impediate Cause (Final disease or condition resulting in death)	tions that caused the death cause on each line. Due to (or as a consequence)	Do not enter					Approximate Interval Between Onset and Death
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events c. c.	Due to (or as a conseque	ence f):	emia	77100			
68760,	tificate be executed ig physician and as the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a consequ	ence of):	SCUP)			
	certific ding p	/Mec	IF FEMALE: 23c	. If yes, outcome pf pregnar	ncv				23d. Date of deliv	on.
.O. Box	law requires that the death certificate be executed as been signed by the affending physician and 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 □E	Ectopic pregnanc Other <i>(specify)</i> _	у		Month	Day Year
Д	quires that en signed b uld be deta	by	Part II. Other significant conditions contri	buting to death but not resul	Iting in the und	lerlying cause giv	ven in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to t	_
I Reco	The arte har page	Completed						24a. Was an autopsy performe	24b. Were autoprior to codeath?	opsy findings available impletion of cause of
Vita	lclan: certific ector,	Be	25. Was case referred to medical examiner?	spital:		_ lott	ner.	h (Check only one)		
0	y Phys er this eral dir	٦. ا	1 Yes 2 No	28a. Date of Injury	28b. Time of	3 □ DOA OII 28c. Inju Wo	4 □ Nursing Ho	ome 5 Residen 28d. Describe how	ce 6 Other (Speci injury occurred	fy)
Division or Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification is the funeral director, it is a funeral director.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of injury - At hor building, etc. (Specify	Injury me, farm, stree)	M 1□]Yes 2□No	28f. Location (Stre	eet and Number or Rur State)	al Route Number,
	spital	al Ce	29a. Certifier 1 Certifying Physic	cian: To the best of my know	wledge, death	occurred at the ti	ime, date and place,	and due to the cau	use(s) and manner as	stated.
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	(Check only 2 Medical Examine one)	r: On the basis of examinat and manner stated.	ion and/or inve	estigation, in my	opinion, death occu	rred at the time, da	te and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Month)	Day, Year)
			30. Name and address of person who com	pleted cause of death (Item		rint)	01807		010010-	,
6+	1 EB		Koman Sivat	rumar. 1	Ronc	-, <u>Sa</u>	enting	mn	21801	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 7 20	32. Regionar's Signat	ture	Carl ,	0			

ORIGINAL

			For 1 _ State	State of Ma	aryland		artment of I	Health and N	lental Hy				
,	-		Registrar 1. Decedent's Name (First, Middle, Last)			illicate of	Deain	2. Date of D	Reg. No.	200	1 29	25
	Physicia		Mary Kraynek Call						Month	Day	2007	04:45	5 Ам
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City. Town.	or Location of Death			County of Dea		A
	examin	er	Anne Arundel Medic				Annapol				Anne Ar		
-	Funeral		5. Social Security Number 6. Se	x 7. Age	e (In yrs. la:	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth	9. Bi	rthplace (State	or Foreigr
ŀ	Director		193-01-5781 15 Usual Residence of Decedent	JM 212√AF	89	Yrs.	Months Days	Hours Min.	05/26/	1918	Per	insylvan	iia
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside C	
	e Mar la-f s tified	Funeral Director	Maryland Anne Arur	ıdel	Riva								2 No
	ith th	Dire	10e. Street and Number				10f. Zip Code				zen of What C		
	ath w	ral	3041 Pike Drive				21140				ted Sta		
	er de Items Ter IT	nue	11. Marital Status	12. Was Decedent I Armed Forces?		. 13. \	Was Decedent of I f Yes, specify Cut	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	Race - Am Black, Wh		
2020	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🐧 N If Yes, Give Year or Dates:	NO		I□Yes 2 X No				Specify:	White	
5	"nati	lete	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	lent's Usual Occu	pation during most of worked)	king	16b. Ki	nd of Business	s/Industry	
7	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		memaker	:a)		H	ome		
7	filed Hygie ther int, th	ပို	17. Father's Name (First, Middle, Last)			110	inchiakci	18. Mother's Nam	e (First, Middle				
<u></u>	ld be ental ked o	To Be	Wassyl Kraynek					Antonet	te Soko	1			
2	shou nd M mar	-	19a. Informant's Name/Relationship (T)	rpe. Print)		19b. Mailir	g Address (Stree	t and Number or Ru	ral Route Num	ber, City o	r Town, State,	Zip Code)	_
Ž	C1 (0 0) (5		Stephen V. Callaha	n/Son		3041	Pike Dri	ve, Riva,	Marv1a	and 2	1140		
ָה ה	ss 1 a of Hear item		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Pla	ce of Dispo	sition (Name of natory or other pla		Date	T	cation - City o	Town, State	
	Page nent c		1X Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)					metery 09/1	.0/2007	Ar1	ington	, Virgi	nia
a	permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tra once.		21. Signature of Puneral Service Licens	ee		22	. Name and Addr	ess of Facility Geo	orge P.	Ka1a	s Fune	ral Home	e
_	89589		1/WWW			29	73 Solon	ons Islar	nd Rd.,	Edgew	ater, 1	MD 2103	7
	1.43		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused ne cause on each lir	the death.	Do not ent	er the mode of dy	ng, such as cardiac	or respiratory	arrest,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition	Pos	· · ·	001/	+					Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							
	ZAGIIIIIGI	-	Sequentially list conditions,	Due to (or as	a conseque	nce of):							
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	rice oi).							
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):							
500	siciar buri	dical E		4									
9	ificate g phys	edic											
5	anding use	N.	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			1r:.			2	23d. Date of de	elivery	
	deat e atte	icia	in the past 12 months? 1 □ Yes 20 No	4☐Pregnant at]Ectopic pregnand] Other <i>(specify)</i> _	у			Month	Day	Year
	w requires that the death certific s been signed by the attending p should be detached for use as	Physician/Me	9 ☐ Unknown	9∐ Unknown									
ה ס	es tha	by F	Part II. Other significant conditions co		ut not result	ing in the ur	nderlying cause gi	ven in Part I.	23e. Did			to the cause of	
2	equir sen si ould	ted	DEMENTI						1	Yes 2	No 3□F	robably 4 🗆	Unknown
2	law r as be	Completed							24a. Was	s an opsy	24b. Were a	utopsy findings completion of c	available
=	The aate h	Son							perl 1∐ Yes	formed? 2 No	death? 1 ☐ Ye		
	Physician: The law this certificate has braid irector, page 2 si	Be (25. Was case referred to medical examiner?				T-	26. Place of Dear	th (Check only	one)	-		
5	hysl this c	ပ္	I les zu	lospital:		R/Outpatien	I 3 L DOA	ner: 4 Nursing H				ecify)	
	ing offe	iuo	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry y Year) 2	28b. Time of Injury	Wo		28d. Describe	how injur	y occurred		
2	ttend death tor:	cati	2 Accident investigation 3 Suicide 6 Could not be	280 Place of inju	unz - At hom	o form etc		Yes 2 □No	20f Logation	/C 4== = 4 = =	of Alexandra a see F	Control Device Man	
2	after Direction by	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	io, iaiiii, Slf	eet, factory, office			(Street and own, State		Rural Route Nur	wer,
	spital ours ours reral filled		29a. Certifier 1 Certifying Phy	sician: To the best of	of my knowl	ledge, death	occurred at the t	ime, date and place	and due to the	e cause(s)	and manner	is stated	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Exam one)	ner: On the basis of and manner sta	f examination	on and/or in	vestigation, in my	opinion, death occu	rred at the time	e, date and	place, and du	e to the cause(s)
	To the	Me	29b. Signature and title of certifier		_		29c. Licen	se number		29d. Dat	e signed (Mor	th, Day, Year)	
	> - 0					_	73	7037		3	23/-	7 09	20

1304 State

Douglas Mitchell
31. Date filed (Month, Day, Year)
AUG 2 4-2007 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parkway, Annapolis, Md. 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:25 A.M. Bobby Franklin Chandler Angmit 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1/23/1934 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min 1 XXX 2 F 73 255-48-6941 ĞÃ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MDAnne Arundel Severn 1 ☐ Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1340 Brenda Rd. 21144 USA Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1∑Yes 2□No Vietnam If Yes, Give Year or Dates: 1 Never Married 2KMarried 1 ☐ Yes 🂆 No White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Admin U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Paulina Mathews James Ottis Chandler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Chandler 1340 Brenda Rd. Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 🕏 remation 3 ☐ Removal from State 8/29/2007 Metro Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, Md 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each it.e. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed τ m burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 🗌 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28a 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes a ☐ Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, or Attending

hours after death uneral Director; filled in by within 24 hours a

To the Funeral L Hospital

State Registrar 4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

All Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

Cupker bksturi Deve,

AUG 2 7 2007

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Anthon 0628 M chert ppuccio /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Med Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/01/1938 9. Birthplace (State or Foreign Country) NY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1**½** M 2□ F 062-30-1114 69 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show MD Anne Arundel Odenton 1 □Yes XXINo notified Director 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a or Examiner must be 509 Higgins Dr. 21113 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1224 es 2 No 19
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1955 1 ☐ Never Married 2134 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2001No White Completed by 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chiel Warrant Officer U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Rafaele Anthony Cappuccio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Cappuccio Wife 509 Higgins Dr. Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot XXBurial 2 Cremation 3 Removal from State Arlington National 10/31/2007 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licenses 7 -0 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failube. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) croman /Medical Due to (or as a conservence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending p IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No death? 1 ☐ Yes certificate 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 6222 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD arah egistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29259 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** CROOK 11.06 AM OUIS AUGUST 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS HOSPITAL BALTIMORE JOHNS If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X**M 2□ F 220-52-5756 58 MARYLAND Director FEB. 13, 1949 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f shi notified a MD QUEEN ANNE STEVENSVILLE 1XX es 21 No Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? an "natural", or Items 23a or Medical Examiner must be 21666 9411 ROMANCOKE ROAD USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Date 1:968-1971 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: WHITE <u>۾</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. the WATERMAN CRABBING INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill feath and Mental Hitem 27 Is marked oth other traumatic even Be THOMAS H. CROOK, JR. HELEN HUNTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY J. CROOK/ WIFE 9411 ROMANCOKE ROAD, STEVENSVILLE, MD 21666 If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 XBurial 2 □ Cremation 3 □ Removal from State SPRING HILL CEMETERY 8-20-2007 EASTON, MD 21601 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. JOHN R. MERCERON 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 3 DAYS PULMONARY EDEMA /Medical Due to (or as a consequence of): Examiner NON SMALL CELLLUNG CARCINOMA 6 MONTHS Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1XYes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No page 2 s autopsy 2 No 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

the death certificate be executed Division or Vital Records, P.O. Box 68760, Attending after death Director: / in 24 hours.
the Funeral Directory filled in by

death v

filed within 72 hours after

Maryland 21215-0036

Baltimore,

12+VA

To the Hos within 24 ho To the Function

Hospital or

After

State Registrar

Medical

1 6 2007

29b. Signature and title of certifier

E. Vishnu

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be

determined

VISHNU DEEPIKA EVURI, JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MD 21287

and manner stated

Deepika

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

AUGUST 14, 2007

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of perion who completed cause of death (Item 23a) (Type, Print)

2007

M.D.

Registrar's Signature

Vladimir Rakhmanin,

31. Date filed (Month, Day, Year) AUG 28

D0059414

18101 Prince Phillip Dr. Olney, MD 20832

8/21/07

			1- State of Maryland / Dep		Mental Hygie	ene
		-	1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. 2. Date of Death	. No. 2007 29261
	Physici		John L. Doerzbacher		Month 08/22	Pay Year 0318am ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl		4c. County of Death
	Zam	Ø.	518 Mystic Lane	Arnold		Anne Arundel
H	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 89 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You 02/18/19	
	pu.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	f shoved at	or	MD Anne Arundel Arnold	ocation		1 ☐ Yes 🏋 No
	the N 28a-i	rect	10e. Street and Number	10f. Zip Code	10a	. Citizen of What Country?
	h with	al D	518 Mystic Lane	21012		USA
136	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2™No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
9500-612	72 hou natura lical E	eted		edent's Usual Occupation e kind of work done during most of wor	king 16	b. Kind of Business/Industry
Z	ne. han "l	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) Machine Repairman		Westinghouse
7	illed w Hygie ther t	ပို	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma	
/Iand	0 = 0 %	To Be	Elmer E. Doerzbacher		Meerhoff	iden daniane)
Mary	permit. Pages 1 and 2 should by Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic es once.	-		ling Address (Street and Number or Ru	ıral Route Number, C	City or Town, State, Zip Code)
Σ ()	and and m 27 m 27				d, MD 210	
saitimore,	it of H		1 Bunar 2 Cremation 3 Removal from State	osition (Name of ematory or other place)		c. Location - City or Town, State
	it. Pa artmer ortant: njury		4 □ Donation 5 □ Other (Specify) Metro Cre 21. Signature of Furecal Service Licensee	ematory 8/24 22. Name and Address of FacilityHar		ltimore, MD
g	Depz Impo any l		1 /4/ / / /	12 Ridgely Ave. Ar	•	
ľ			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate
	Physician		Immediate Cause (Final disease or condition	ebrel vesarla a	1	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	110.	1	
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	may 1412 17/1960	se)	
	od dansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
Š	e exec ian an urial-tr		resulting in death) Last Due to (or as a consequence of):			
8/60,	icate be executed physician and s the burial-transit	dical	d			-
S X	certific iding p	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery
POX	death atter	iciar	in the past 12 months? 1 Use birth 2 Fetal death 3 1 Ves 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	·	Month Day Year
5	at the by the tache	hys	9 ☐ Unknown			
S,	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death but not resulting in the	ınderlying cause given in Part I.	23e. Did tobad	cco use contribute to the cause of death? 2 ★No 3 □ Probably 4 □ Unknown
Hecords	requipeen should	eted			-	
ě	he law has ge 2 s	Completed	High Blood gressine		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
VII	an: T lificate or, pa		25. Was case referred to medical	26 Place of Do	th (Check only one)	No 1 ☐ Yes 2 ☐ No
	Physician: r this certific ral director,	o Be	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Othor		e 6 ☐Other (Specify)
0	ng Ph fter th neral	n: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Injury 28b. Time (Month, Day Year)		28d. Describe how	
0	tendir eath. or; A the fu	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
DIVISION	To the Hospital or Attending Physician: The law requires that the death certificating the hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Certification:	4 ☐ Homicide determined determined building, etc. (Specify)		City or Town, S	
	Hosp 24 hou Funei etely fil	edical	29a. Certifier (Check only one) (Check only one)	th occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the caus urred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	Fo the within Fo the Somple	Mec	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
	CAN !		I MA V	058686		8/23/07
	0/2		30. Name and address of person who completed cause of death (tem 23a) Type	Print) Hishur Ar	well p	21012
	Sta Begistr		31. Date filed (Month, Day, Year) AUG 2.7 2007	1.0.		

State of Maryland / Department of Health and Mental Hygien 2 8 0 7 29262 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Sandra Dodson 2:00P September 3, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 29681 Jennifer Drive Mechanicsville St. Mary's | Months | Days | Hours | Min. | B. Date of Birth (Month, Day, Year Dec. 11, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖺 F Director 214-72-3220 51 Yrs 1955 Massachusetts Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show traumatic event, the Medical Examinar must be notified at Director 1 Yes 2 No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 29681 Jennifer Drive 20659 permit. Pages 1 and 2 should be filed within 72 hours atter death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a any hijury or other traumatic event, the Medical Examinar must.) USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2₹ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Arthur Tyler Nancy Elizabeth Lober ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fuller A. Dodson, Jr./Spouse 29681 Jennifer Dr., Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Brinsfield-Echols 9/5/2007 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Reference and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., CHarlotte Hall, MD 20622 21. Signature of Funeral Service Lice M00817 colw 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Brail tumon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ng physicien and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ♣ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at id be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 48Unknown 1 Tyes 2 No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗫 Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62042 an up 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) Dr. Karen Bauer Mechanicsville, Maryland 20659 31. Date filed (Month, Day, Year) SEP 0 5 2007 32. Registrar's S State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Regina Louise Edwards /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Memoria If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 213-44-9702 1 □ M 2 X F 60 12-21-1946 Baltimore City Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County a or 28a-f sh t be notified Md Talbot St. Michaels Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 Spencer Avenue 21663 USA Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 honent of Health and Mental Hygiene. Int: If item 27 is marked other than "natury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Child Care <u>Child Care</u> 7 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hubert Joseph Kraft June Elizabeth Stickly မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 Doverbrook, Easton, Md. 21601 ^{19a.} Informant's <u>Name/Relationship (Type. Print)</u> Bambi Edwards (daughter) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory 8-17-2007 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Dover, De. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Carroll Hurley Funeral Home, O. Box 518, St. Michaels Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ron- sudl cell Physician anc /Medical Due to (or as a consequence of):

Examiner

Examiner

Physician/Medical

physician and s the burial-trans attending properties for use as ed by the a funeral After within 24 hours after death

To the Funeral Director;
completely filled in by the t

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last IF FEMALE: 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Be Completed Crown 25. Was cose referred to medical examiner? 1 ☐ Yes 212 No Certification: To 27. Manner of Death

Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

28a. Date of Injury (Month, Day Year)

and manner stated

Due to (or as a consequence of)

Due to (or as a consequence of)

9 Unknown

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3 ☐Ectopic pregnancy 5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown

Dav

Year

Approximate Interval Between Onset and Death

29263

2026 M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 🎇 No

Year

2007

Black, White, etc.

White

a1 00 1

24a. Was an autopsy 2/2 No 24b. Were autopsy findings available prior to completion of cause of 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

John St. Easten, ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Norte 2195. West w

5 Pending investigation

6 ☐ Could not be

31. Date filed (Month, Day, Year)
AUG 1 7 2007

Hospital:

3. Registrar's Signature

State Registrar

Ì

Medical

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year, AUG 2

0 2007

07-06824 Daisy Flores Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 29265

		- For State Registrar	(Certificate of	f Death	7		R	Reg. No.		,
Physician	n/	 Decedent's Name (First, Middle,L 					-	2. Date of Dea	ath Day Yea		Time of Death
Medical Examin			ixabel Flo		4b. City. Te		action of Doot		er 2, 2007	of Dooth	1822 hrs
		4a. Facility Name (if not institution, g 1804 Merrimac Drive	ive street and number)		Hyatts		ocation of Deat		Prince G		3
Funeral		5. Social Security Number 6.	Sex 7. Age (In)	rs. last birthday)	If Unde		If Under 24Hr Hours Min	_	rth(MM/DD/YYYY		
Director	ŀ	577-17-7092 1	M 2XF	60 Yrs		Days	110015	Feb.	12, 1947	Coun	ElSalvador
And a second name to the factor of the second	100	10a. State 10b. County	10c.	City, Town or Locat	ion					1	0d. Inside City Limits
* .	į.		Georges H	yattsvill		0 1			10g. Citizen of Wh		1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.		10e. Street and Number 1804 Merrimac	Drive		10f. Zip	783			U. S.		y?
after death with the Maryland "I", or items 23a or 28a-f sho	Funeral	11. Marital Status 1 Never Married 2 X Marrie	12. Was Decedent Ever Armed Forces?	* · · · If Y			nic Origin? (S Mexican, Puert	Specify Yes or No o Rican, etc.)	0- 14. Race White		n Indian, Black,
after d	현	3 Widowed 4 Divorce	ed If Yes, Give Year		Yes 2	No	specify: Sa1	vadoran	Specify: 1	White	9
natur,		15. Decedent's Education (Specify		d) 16a. Deceder			n (Give kind of OO NOT use re		16b. Kind of Bu	siness/Ind	dustry
15-0036 Ifled within 72 hours I Hygiene, and other than "natural of other than "natural", the Medical Exam	Completed	Elementary/Secondary (0-12) 6th	College (1-4 or 5+)		enan			inca	Metrop	olita	an Cleaning
215-0036 be filed within 77 ntal Hygiene. Red other than ent, the Medical	ᇬ	17. Father's Name (First, Middle, La				18			Maiden Surname)	
O 9 2 4 2 1	a	Jose Antonio Ar		200119-5			1.		Nolasco		
more, MD 21215-003 Pages I and 2 should be filed within ent of Health and Mental Hygiene, mit. If item 27 is marked other transmatic event, the Mea	2	19a. Informant's Name/Relationship Jaime Ernesto F				•			mber, City or Tow $11\mathrm{e}$, Md .		Zip Code)
s 1 and s Healt If item		20a. Method of Disposition		20b. Place of Dispos crematory or ot		e of ceme	etery,	Date	20c. Location -	City or To	own, State
Baltimore, permit: Pages I an Department of Hea Important: If ite	- 1-	1 X Burial 2 Cremation 3 4 Donation 5 Other Speci	fy:	Glenwood	Ceme	-		pt.8,20			ton, DC
Baltir Permit: Permit: Permit: Importaring injury or		21. Signature of Fundal Service Llo Wanaa C.	Bacon (C361 22.1	Name and A		W .	H. Baco	on Funer Washing	al Ho ton,	Dme, Inc. DC 20010
Physician /Medical		23a. Part I. Enter the disease, or cor failure. List only one cause on		eath. Do not enter t	he mode o	f dying, su	ich as cardiac	or respiratory ar	rest, shock, or he	art .	Approximate Interval Between Onset and
caminer	1	Immediate Cause (Final disease or condition resulting in death)	a. Head injuries Due to (or as a consequent								Death
31. 190		Sequentially list conditions,	b								
	in in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequent	ice or):							
	<u> </u>	events resulting in death) Last	Due to (or as a consequent	ce of):					1.2		
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8760, ifficate be us physicis the buri	Ĭ,	IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome of	pregnancy					23d. Date of		
- OD 10	gan	past 12 months?	1 Live birth 4 Pregnant at time	of dooth	etal death ther (Spec		Ectopic pregr	nancy	Month	Da	y Year
Box 68 te death certi the attendin	Physicia	1 Yes 2 No 9 V Unknow	yn g Unknown	J O	iner (Opec						
P.O. es that the igned by the detache		Part II. Other significant condition	s contributing to death but	not resulting in the	underlying	cause giv	en in Part I.				e cause of death?
S, P	ᄝ	<u>Chronic alcohol</u>	abuse								bly 4 🗹 Unknown
Division of Vital Records, tal or Attending Physician: The law require as after death. al Director: After this certificate has been si led in by the finneral director, page 2 should be as the finneral director, page 2 should be as a should be as a should be	Completed by							24a. Was	psy r		psy findings available mpletion of cause of
Rec The cate	5							1 Yes		✓ Yes	2 No
Vital Re	å,	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2			.0	f Death (Check ther:		3	401 -	2
Phys Phys	암	1 Yes 2 No 27. Manner of Death	, inpatient i	2 ER/Outpatient		DA Sc. Injury		ing Home 5	Residence 6 how injury occurr		Scene
on of nding Ph. th.	<u>ë</u>	1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)		· ·		s 2 X No	subject			
isior r Attend er death rector:	icat Licat	2 X Accident Investiga 3 Suicide 6 Could no	28e Place of Injury -			office buil	Iding, etc.	28f. Location	(Street and Numb	er or Rura	I Route Number, City
Divis	Certification:	3 Suicide 6 Could no determine		d in reside	nce			or Town, 1804 Mer	_{State)} rimac Dr.	Hyatts	sville, MD
	ल		ician: To the best of my kno er: On the basis of examinati								
To the within To the comple	ğ -	29b. Signature and title of certifier	and manner stated.			License			29d. Date sign		
		Allhua Dear	self with			O.C.M	.E.		September	3, 200	7
0 19	H	30. Name and address of person wh	11 6	(Item 23a)							
1-(2)			Assistant Medical Exa		Penn Str	eet, Ba	ltimore, MD	21201			
Sta Registra		SEP 0 7 2007	32. Registrar's Signature	and I							
- region	للت	MLT II I ZUUI	Walled D.								

State of Maryland / Department of Health and Mental Hygiene 2007 29266

		•	State Registrar	•	Ce	rtificate of	Death		Reg. No.	007	2 3 2 0 0
п			1. Decedent's Name (First, Middle, L.	ast)				2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Dolores Marie	Fitzhugh					1, 200		8:00 a ^M
ř.	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	r Location of De	ath	4c. Co	ounty of Deat	th
			10124 52nd Aven				ege Par				orge's
	Funeral		5. Social Security Number 6. 578-58-4515	Sex 7. Age (In yrs. 1 M 2/2 F	last birthday	If Under 1 Year Months Days		in. 8. Date of Bir Month, Da	rth a <i>y, Year)</i>	9. Birt	thplace (State or Foreign ountry)
٧.	Director		Usual Residence of Decedent		TIS.			Feb. 2	5, 194	13 Wa	shington, DC
	and and		10a. State 10b. County	10c. C	ity, Town or L	ocation					10d. Inside City Limits
	Manyl f ehc	0									1 ☐ Yes 2 ☑ No
	the 28a	Director	Maryland Mon 10e. Street and Number	tgomery	Olney	10f. Zip Code			10a. Citizer	n of What Co	ountry?
	with 3a or		3435 Bantry Wa	.y			20832			USA	
	death with the Maryland ma 23a or 28a-f ehow press be rediffed at	Funerai	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	. Was Decedent of H If Yes, specify Cubi	lispanic Origin?	(Specify Yes or No	o- 14.		erican Indian,
٥	after or ital		1 Never Married 2 Married	Armed Forces? 1 Yes 2 No				ierto Rican, etc.)		Black, Whit	
000	hours after tural', or its	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2ŒNo	Specify:		Sp	oecifyWhi	te
- C	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Itama 23a or 28a-f ehow other than "natural", or Itama 23a or 28a-f ehow event, the Markleal Exa strike mast be motified at	Completed	15. Decedent's I (Specify only highest g	Education rade completed)	16a. Dece	edent's Usual Occup e kind of work done	ation during most of v	workina	16b. Kind	of Business	/Industry
7	within 72 ene. than "nai	ig.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)				~
V	filed w Hygier other ti		12		Adm1	.nistrativ				Health	Care
and	id be fii ental H ked oti ic even	Be	17. Father's Name (First, Middle, Las Charles H. Coni					Name <i>(First, Middle</i> arie A. To			
2	should be ind Mental s marked umatic ev	2			400 14 1						7: 0 11
Z Z	C1 00 = 00		19a. Informant's Name/Relationship Thomas Leo Fitzh		1	ling Address (Street Laconia					
a)	s 1 and of Health item 27 other to	1	20a. Method of Disposition	20ь.	Place of Disp	osition (Name of			J .		Town, State
Baitimor	permit. Pages Department of I Important: If It eny injury or o		1 Burial 2 Gremation 3	☐Removal from State	cemetery, cre	ematory or other place. .itan Cren	<i>∞)</i> Aug natory	gust 27 2007	770		Winaini -
	artme artme ortan injur		*4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	,,							, Virginia
ğ	permit. Departr Importa eny inji		J. Ken Skile		4	rancis dde 100 Univer					ng, MD 20901
	∯ 1. ————————————————————————————————————		23a. Part. Enter the disease, or con shock, or heart failure. List only	mplications that caused the dea y one cause on each line.	th. Do not er	nter the mode of dyin	ng, such as card	diac or respiratory a	arrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	, Failure To	Thriv	re					Onset and Death Weeks
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):						
	Examine		Sequentially list conditions,	b. Dementia							Months
	sit sit	Examiner	cause (Disease or injury	Dua to (or as a nonse	quentra oty:						
-	and I-tran	хап	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):						
2	be e				,,						
09/89	death certificate be executed e attending physician and id for use as the buriat-transit	Medical		d							
×	certific nding p use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					230	d. Date of de	livery
ģ	attendi	ciar	in the past 12 months?	1☐Live birth 2☐Fet 4☐Pregnant at time of		□Ectopic pregnancy □ Other (specify)	у			Month	Day Year
o.	y th	Physician/	9 Unknown	9□ Unknown							
т. Г	w requires that been signed to should be deta	by PI	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to	o the cause of death?
cords,	quire in sig uld b	pe pe	Insulin-Depende	nt Diabetes Me	llitus	5.,		_ 1□	Yes 2 🗘	Mo 3□P	robably 4 Unknown
ပ္ပ	s bee	oleti	Transient Ische	emic Attacks				24a. Was	s an	24b. Were a	utopsy findings available completion of cause of
Ä	aician: The taw requires that certificate has been signed b irector, page 2 should be deta	Completed						- auto perfe	ormed'/	death?	s 20 No
Vital		0	25. Was case referred to medical				26. Place of [Death (Check only			242.10
	nyaician: iis certific director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatie	ent 3□ DOA Oth	ner: 4 🗆 Nursin	g Home 5 ☐ Res	idence 6	ther (Spe	ecity) Son's
10 C	ding Ph h. After thi funeral		27. Mann of Death 1 Vivatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Injui		28d. Describe			residence
<u>0</u>	Attendia death. ctor: Al y the fu	atlo	2 ☐ Accident investigati	on			Yes 2□No				
DIVISION	or A	Certification:	3 ☐ Suicide 6 ☐ Could not determine		nome, farm, s ify)	treet, factory, office		28f. Location (City or To	(Street and fown, State)	Vumber or R	lural Route Number,
_	spits ours bera fille		29a. Certifier 1 Certifying F	Physician: To the best of my kn aminer: On the basis of examin	owledge, dea	ath occurred at the ti	me, date and pla	ace, and due to the	cause(s) ar	nd manner a	s stated.
	To the Hos within 24 h To the Fur completely	fedical	one)	and manner stated.	anwor			active at the thue			
	To To Con	Σ	29b. Signature and little of certifier	///	-111	29c. Licens			29d. Date s	signed (Mon.	th, Day, Year)
L				// //	VV	₩ D3	38457		Augu	ıst 27	, 2007
			30. Name and address of person wh				#277	Cilvon C	nnine	MD 2	0006
	A		Nakul Gbyal, N	3801 Inter		idi prive,	, #ZII,	Silver S	bring,	, MD 2	.0900
	Sta Registr		31. Date filed (Month, Day, Year)	2007 32. Agistrar's Sign		hack o					

		•	For State Registrar	State of Marylan			r Health and r of Death	R	leg. No.	1 2 3 2 0 1
7	Physici		1. Decedent's Name (First, Middle, Las Mani		Garr	ett		2. Date of Dea Month August	Day Year	
	/Medio Examin	1000	4a. Facility Name (If not institution, give	own Road		Parl			4c. County of De	more
	Funeral Director		5. Social Security Number 218-40-7657 Usuel Residence of Decedent	7. Age (In yrs. 86	Yrs.	If Under 1 Y Months Da		(Month, Day	, 1921 Bec	ithplace (State or Foreign Sountry) :kleysville,MD
	Maryland I-f show	tor	10a. State 10b. County MD Baltim		y.TownorLo					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	h with the	al Director	10e. Street and Number 18429 Middlet	own Road		10f. Zip Co		1	10g. Citizen of What C	Country?
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Itama 23a or 28a-f show eumatic event, the Medical Evantral must be tradified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	}	Was Decedent f Yes, specify 1 ☐ Yes 2 ☒	of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, lite, etc. White
21215-0036	filed within 72 hou Hyglene. Ither than "naturi ant, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Deced (Give life. L		ecupation one during most of wor stired) Maker	king	16b. Kind of Busines	
Maryland 2	ould be fited Mental Hygis arkad other tatic event, II	To Be Co	17. Father's Name (First, Middle, Last) Richard Trace	ey.	1	1101110	18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
Mary	- C	-	19a. Informant's Name/Relationship (7	Type, Print)			reet and Number or Ru DWellvill			Zip Code) S , MD 21874
altimore,	1 a Hei Hei Sthe		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Dispo semetery, cren	sition (Name of natory or other	sep	Date ot. 4,	20c. Location - City of White H	or Town, Slate
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Fune a Service Vicen	rlenstern	and the same of th	24 Se	cond St.	New Fr	eedom, P	
	Physician /Medical		23a. Park. Enter the disease, or comp shock, or lear failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Cancer of	they	or the mode of	relastatic	1-1	rest,	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of the consequence o	uence of):				0	0
8760,	ficate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or as a conseq	uence of):					
O. Box 6	death certi e attending ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c	Ideath 3	Ectopic pregr Other (specif			23d. Date of d Month	lelivery Day Year
۵.	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions o	ontributing to death but not res	ulting in the u	nderlying caus	e given in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
Reco	The law re ate has bee page 2 sho	Completed						24a. Was autop perfor 1 🗆 Yes	sy prior to death	autopsy findings available o completion of cause of ?
V ita	Physician: this certificatal director, p	Be	25. Was case referred to medical examiner?	Hospital:			Othor	ath (Check only o		
of	Phys this al dir	<u>۱</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2	ER/Outpatier 28b. Time of		4 🗆 Nursing F		lence 6 Other (Sp now injury occurred	pecify)
Division of Vital Records,	fing After fune	Certification;	1 Natural 5 Pending investigation 3 Suicide 4 Homicide Could not be determined	(Month, Day Year)	Injury ome, farm, str	М	Injury al Work? 1 Yes 2 No		Street and Number or	Rural Route Number,
Ω	o Hospital or Attenc 24 hours after death Funerel Director: etely filled in by the i	edical Cer		ysician: To the best of my kno niner: On the basis of examina and manner stated.						
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	(MD		29c. L	cense number		29d. Date signed (Mo	nth, Dəy, Yəar)
-	6		30. Name and address of person who Richard C. Habe	111 m	t. Co	Print)	Rd Pa	arkton	mo :	31130
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	25 .				

29268 State of Maryland / Department of Health and Mental Hygiene20071 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Biscoe Graves September 3, 2007 11:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's 29734 Marshall Road Mechanicsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 1 M 2 □ F Yrs. Director 70 March 30,1937 217-36-8666 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location r than "naturel", or items 23s or 28s-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 20No Direct Maryland St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? 29734 Marshall Road 20659 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 ★No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 9 Truck Driver Transportation marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be nent of Health and Mental Graves Ruth Wright ၉ Samue1 R. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i item 27 i 29734 Marshall Rd., Mechanicsville, MD 20659 Wanda Luckett/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State = 5 permit. Page Depurtment of Important: If any njury or once. 4 Donation 5 Other (Specify) Mt. Zion Methodist 9/6/2007 Mechanicsville, MD 21. Signature of Funeral Service License Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 WH00817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIO PULMONAM **Physician** Y HR) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physicien and for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. bete has been signed page 2 should be del 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ MALNUTRITION Yes 2 No 3 Probably 4 Unknown Be Completed CHRONIC PAIN 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed? 2 No 1☐ Yes Hospital or Attending Physician: After this certification, funeral director, 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funerel Direct completely filled in by filled in by 4 | Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ۽ 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 4/07

Registrar DHMH 17 Rev 1/2001

State

Mechanicsville, Maryland 20659

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr. George Leon

31. Date filed (Month, Day, Year)

SEP 0 5 2007

		1	For	partment of Health and M Certificate of Death	ental Hygiene Reg. No	0007 00000
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
	Physicia		Salvatore Victor Greco		September	
	/Medic Examin	-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40.	. County of Death
			21723 Saratoga Drive	Lexington Park		st. Mary's
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		121-09-7963	S	06/19/1918	New York
	p >	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	r Location		10d. Inside City Limits
	aryla shor	5	133.33.33			1 ☐ Yes 2 💆 No
	the N	Directo	Maryland St. Mary's Lexingto	10f. Zip Code	10g. Cit	tizen of What Country?
	a or				II-n -	ited Ctates
	eath	Funeral		20653 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	ited States 14. Race - American Indian,
	ter d	ᇤ	1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
936	flied within 72 hours after death with the Maryland Hygiene. Hygiene. than "natural" or Items 23a or 28a-f show ther than "natural" or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify: White
ĕ	2 hor	ted	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of worki		(ind of Business/Industry
21	thin 7 e. an "r Med	ed l	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired)		
2	er th	Completed		ineer	(First, Middle, Maider	S. Government
g	be filed within 72 hours after death with the Marylan Hygiene. d al-Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)			in Surriame)
<u>ya</u>	Men Men arke	မ	Frank Greco	Filomena Mailing Address (Street and Number or Run	DiGiorno	or Town State Zin Code)
/ar	2 sh and is m		, , ,			
6)	l and Health em 27 ther t		20b Place of D		Lexington Date 20c. L	Park, MD 20653
more, Maryland 21215-0036	Pages 1 and 2 should be filed w nent of Health and Mental Hygier ant: If Item 27 is marked other th ary or other traumatic event, the		1⊠ Burial 2 □ Cremation 3 □ Removal from State Charles	rematory or other place) Memorial	10007	
Ξ	t. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Specify) Gardens 21. Signature of Funeral Service Licensee			nardtown, Maryland
Bai	permit. Pag Department Important: I any Injury o	1	Tyle Jones	22955 Hollywood Roa		
	-		Kyle S. Simons M01206 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)	Concer		Onset and Death
	Physician /Medical		disease or condition resulting in death) a			
	Examiner					
k	y salvi	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying):		
	d d ansit	Examiner	Cause Enter Underlying Cause (Disease or Injury that initiated events C.			
o,	an an rial-tr	E	resulting in death) Last Due to (or as a consequence of):		
8760,	cate be executed oblysician and the burial-transit	dical	d			
9	ng ph as th	Med	IF FEMALE:			
Вох	leath certific attending p	an/l	23b. Was decedent pregnant 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
	e deg	Sici	1 □ Yes 2 □ No 9 □ Unknown 4 □ Pregnant at time of death 9 □ Unknown	5 Other (specify)		
P.0.	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as:	Physician/Med	Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
	w requires that been signed be should be det	by	T at the Strong digital and the strong digital and digital and the strong digital and the strong digital and the s		1 ☐ Yes	2 No 3 Probably 4 Unknown
or	requ	Completed			24a. Was an	24b. Were autopsy findings available
3ec	has has be	ig m			autopsy performed2	prior to completion of cause of death?
a			The state of the s	OC Place of Deep	1 Yes 2 N th Check onlone	No 1 ☐ Yes 2 ☑ No
Z:	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1	Other	ome 512 Residence	6 □Other (Specify)
or	Phys r this ral di	년: -	27. Manne of Death 28a. Date of Injury 28b. Ti	me of 28c. Injury at	28d. Describe how inj	
on	ding h. Afte fune	tion	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Inj	jury Work? M 1 Yes 2 No		
Division or Vital Records,	Attending r death. ector: After by the fune	lica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined building, etc. (Specify)	m, street, factory, office	28f. Location (Street a	and Number or Rural Route Number,
ă	al or after	Certification:				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only (C	death occurred at the time, date and place /or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	the H hin 24 the F mplete	Medical	one) and manner stated.	29c. License number		Date signed (Month Day Year)
	To the confidence of the confi	2	29b. Signature and title of certifier Feelle	73418	۶ ا	9/5/67
			30. Name and address of person who completed cause of death (Item 23a) (The Downley M. D. 24035. Three	rype, Print) se Notch Road, Holly	wood Mary	land 20636
	St	ate	David M. Federle, M.D. 24035 Three 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ee Noten Road, noting	wood, mary	Tana 20000
	Regist		SEP 0 6 2007 Amount It Amount			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** SAMIH GEORGE 26,2007 0405 AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL CENTER HESTER RIVER If Under 1 Year | If Under 24 Hrs. | 8 Day KENT 8. Date of Birth (Month, Day, Year)
July 28, 1929 9. Birthplace (State or Foreign Country) Palestine Social Security Number 6 Sev **Funeral** Months Days Hours Min. 1**X** M 2□F 577-54-1503 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" --- any injury or other traumatic exercises. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Queen Anne's Maryland Chester 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1816 Main Street 21619 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mousa Saman Hanneh Sheib 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zohra_B._George/Wife 1816 Main Street, Chester, Maryland 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 30, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee J. Ken Skile 500 University Blvd., W., Silver Spring, MD 20901 23a. P rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prostate Physician adenocar cinoma /Medical Due to (or as a consequence of) Examiner Wex Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tente Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No Macroconsian 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe es 2 1□ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Unpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 2 ☐ Accident 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title f certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG

28

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Frederiek Delboy, M.D. 6602 Church Hill Road, Chester, MD 21620

32. Egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September 4, 2007 Yvonne Hooper 1:00 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8511 Edgewood Church Road Frederick Frederick 8. Date of Birth Month Day Year) March 1, 1928 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign County)
Mary Land **Funeral** Months Days Hours 1 □ M 2√2 F 214-28-0699 79 Yrs. Director Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28a-f show ampingury or other traumatic avant, the Madical Examinant by notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8511 Edgewood Church Road 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (TNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by White 3 XWidowed 4 □ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilfred G. Blank 2 Effie Virginia Delauter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Howard Hooper/Son 21 Zeigler Mill Road, Gettysburg, PA 17325 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gardens Sept. 7, 2007 Frederick, MD 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick MD 21701 23a. Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) the cardiavascular direa **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): .O. Box 68760, Completed by Physician/Medical attending I IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months2 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f □Yes 9 Unknown Division of Vital Records, P. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 No 3 Probably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed /25 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only on Hospital: 1 | Inpatient Other: 4 Nursing Home Sesidence 6 Other (Specify) ဥ 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending s after decrai Director: Afr investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funaral Discompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who complete of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MABEL A. HILL SEPTEMBER 3 2007 4:30pM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Centreville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb 8 1901 Corsica Hills Nursing Home Oueen Anne's 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F 213-44-0991 106 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 □ No Kent Kennedyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11955 Augustine Herman Hwy. 21645 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker College 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cornelius Jarvis Estelle Stradley 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Chestnut St. Centreville, MD. 21617 Judi Beskid (granddaughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 9/10/07 Still Pond Cem. Still Pond, MD. 5 Other (Specify) 4 Donation 21. Innature & Fundral Service Galena Funeral 118 West Cross Stephen MD. Home of Ste St. Galena, L. Schaech 21635 M00510 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygis Important: If item 27 Is marked other I any Injury or other traumatic event, th

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

be executed sician and burial-trans attending physician for use as the buria P.O. Vital Records,

9

Division

the Hospital or Attending

after death | Director: , d in by the f

page 2 s certificate death.

Physician/Medical ρ Completed Be

Examiner

Medical Certification: To

To the Hospital or within 24 hours aft To the Funeral Di completely filled in 5

State Registrar

29b. Signa Name and address of person who complet 16 men

5 Pending investigation

6 □Could not be

determined

2 No

1 Tes

27. Manner of Death

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

1 Natural

29c. License number 00060301

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ed cause of death (Item 23a) (Type Print) (I) 577 5 CHESTENTOWN, MI) 21620

Other: Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

31. Date filed (Month, Day, Year) SEP 1 1 2007 32 Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

		1 - State Registrar	State of M	arylano /		artment of H rtificate of L		лептат ну	0	007	29273
Physici /Medic		1. Decedent's Name (First, Middle, La Walter A. Harris	,					2. Date of De Month	Day	Year 2007	3. Time of Death 2:35 AM M
Examin		4a. Facility Name (If not institution, gir	ve street and number)			4b. City, Town, or	Location of Death		4c. Co	ounty of Death	
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Funeral Director		·	Sex 7. Ag 1 X M 2 □ F	ge (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da			place (State or Foreign ntry)
M seek Siri sa		220-24-5257 Usual Residence of Decedent		77				10/05	/1929	wasn:	ington, DC
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er dea	Funeral	11. Maritai Status	12. Was Decedent Armed Forces?	?	13.1	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14.	Race - Americ Black, White,	
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al Hy l othe	Be C	17. Father's Name (First, Middle, Las	t)				18. Mother's Nam	e (First, Middle	e, Maiden Su	rname)	
Ment Ment arked	인	Walter A. Harri	s, Sr.				Mary E.	_Bowli	ng		
2 short and is mark		19a. Informant's Name/Relationship	(Type. Print) (broth	er_ 19'	b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numb	oer, City or Te	own, State, Zip	Code)
and lealth m 27		Donnell E. Balm	(brothert in-la	W)	606	South Sha	amrock_Ro		el Air	, Mary	land 2101
ges 1		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 [☐Removal from State	cemete	ery, crei	sition (Name of matory or other place	· ;	Date		tion - City or To	
t. Pa tmen tant:		4 □ Donation 5 □ Other (Special		Dulane	≥y V	alley Mem	i.Gd, 09/	07/2007	Timor	nium, M	aryland
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Monee.		21. Signature of Funeral Service Lice	ensee	ſ							ral Home
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		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each i	ine.	not ent	er the mode of dying	g, such as cardiac	or respiratory a	arest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Uem		-						Years
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e dea the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5	Other (specify)				WORTH	Day Year
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Phy er this	-: To	27. Manner of Death	28a. Date of Inju	ury 28b.	Time o	JU DOA	4 LI Nursing H	ome 5 Res 28d. Describe		Other (Specificular)	v) Hospice
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To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	of examination a	e, deatl nd/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s) an , date and pla	d manner as s ace, and due to	tated. the cause(s)
To th To th comp	Me	29b. Signature and title of certifier	/			29c. License	number		29d. Date s	igned (Month,	Day, Year)
		John M.	es in	()		D0061	1199		Sept	, 2, 2	007
. \ 1		30. Name and address of person who	completed cause of c	death (Item 23a)	(Type,						
3+1		Jason Black,	65650 NE	VPa CL	196	65 St. Sc	ite 209	, Tous	ou m	0 212	204

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Ruth A. Hamilton 4:15 PM August 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 19, 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2√ □ F Days Hours Maryland Director 213-46-6926 66 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifled at 10d. Inside City Limits Maryland Frederick Frederick Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 217 Harpers Way 21702 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No white <u>م</u> Specify: 3€ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker own home permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important: If Item 27 is marked other in any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Eleise Ann Teele James Cryer ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21793 Catherine Linton - daughter 9956 Kelly Road, Walkersville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial →2 IXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 8-30-2007 Frederick, Maryland 21. Signature of Funeral Service Licensee... 22. Name and Address of Facility Stauffer Funeral Home Klue 1621 Opossumtown Pike, Frederick, Maryland 23 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ROSEPS **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Exami Partal L and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Day 5 ☐ Other (specify) P.O. the 9□Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 1 ☐ Yes 2 → NO 3 □ Probably 4 □ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy perform certificate 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Hospital or Attending 5 ☐ Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) San 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21701

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

AUG 3 0

400 W. 7th Street, Frederick, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 4, Sept. 2007 ELEANOR KNOPP MARGARET 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Bel Air

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | 4 Harford Upper Chesapeake Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6/13/192 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 1 □ M 2 🗓 F 82 Maryland 212-22-8973 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Jarrettsville MD. Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21084 United States 1420 Knopp Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: White 3K Widowed 4 ☐ Divorced 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supermarket Stock Person 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie Ozella Iley William Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21154 3658 Emory Church Rd. Street, MD. James J. Norris (Nephew) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1. Burial 2 □ Cremation 3 □ Removal from State William Watters Cem 9/8/2007 Cooptown, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Jarrettsville, Maryland Kurtz & Son Funeral Home, P.A. E.G. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each one. Immediate Cause (Final disease or condition resulting in death) INFARCTION MYOCARDIAL a. ACUTE Due to (or as a consequence of) DISEASE CARDIOVASCULAR B.ARTERIOSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pre**g**nancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4⊡Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an DEMENTIA autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner 68760 pe law requires that the death certificate o cate has been signed by the page 2 should be detach Δ After this To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After

Examiner Physician/Medical þ Completed Be Medical Certification: To

Physician

/Medical

Examiner

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Director

. 28a-f show notified at

ed other than "natural", or items 23a or event, the Medical Examiner must be r

Department of Health and Important: If Item 27 is m any Injury or other traum once.

Physician

/Medical

Baltimore,

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
unt: If Item 27 is marked other than "natural", or ite

Director

Funeral

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Completed

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death with the Maryland

27. Manner of Death

3 Suicide 4 Homicide

6 ☐ Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

AVE NUE

29c. License number

29d. Date signed (Month, Day, Year) SEPTEMBER 2007

sank 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH

31. Date filed (Month, Day, Year) State SEP 1 1 2007

29a. Certifier

32 egistrar's Signature

Registrar

completely

		1	For State Registrar	State of N	nai y iai ic	Cer	tificate of L	Death	He	eg. No. 200	1 29277
•	Physicia		1. Decedent's Name (First, Midd						2. Date of Deat Month	Day Year	3. Time of Death 3:20 P ^M
	/Medic	al -	EDNA E K. 4a. Facility Name (If not institution	IRKBRIDE	(r)		4b. City, Town, or	Location of Death	AUGUST	28 200 4c. County of Dea	
	Examin	er	FREDERICK		OSPITA	YT.	FREDER	ICK		FREDE	ERICK
100	Funeral Director		5. Social Security Number 283–14–4148	6. Sex 7. A	Age (In yrs. la	as <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 16	Year) 9. Bi	rthplace (State or Foreign ountry)
	р		Usual Residence of Decedent								10d. Inside City Limits
	Marylar I-f show fied at	tor	10a. State 10b. Count Maryland Fre	y ederick	10c. City	, Town or Lo	nrovia				1 ☐ Yes 2 ☑ No
	th the	Directo	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What C	ountry?
	23a cust b		4950 Tall Oaks					21770		United S	
036	should be filed within 72 hours after death with the Maryland of Mental Hygene. marked other than "natural" or items 23a or 28a-f show martic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	If Ves Give	s? No	1	Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2점 No		ecity Yes or No- Bican, etc.)	Black, Wh	ite, etc.
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7.17	d withi giene. rr thar the N	mo	Elementary/Secondary (0-12)) College (1-4d	or 5+)	I	Homemaker				Home
9	9 E 0 S	Be C	17. Father's Name (First, Middle	e, Last)					,	Maiden Surname)	
<u>\S</u>	2 should be f and Mental I is marked of aumatic eve	၉	James W. Gal			10h Mailie	an Address (Street	Alice Number or Bu		r, City or Town, State,	Zin Code)
ā Z	d 2 st th and 17 is n traun		19a. Informant's Name/Relation Susan Shupe				Tall Oaks			, Maryland	
	ss 1 and 2 should b of Health and Ment item 27 is marked r other traumatic e		20a. Method of Disposition		20b. P		osition (Name of matory or other place	i		20c. Location - City of	
<u>E</u>	Pages ment of I ant: If its ury or o	1	1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other		ite i	uffer	Cremator	y	2007 E	Frederick,	Maryland
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signifure of June 1 Service	e Licensee			2. Name and Addres E. Ridge			uneral Hor Airy, Mar	nes, P.A. yland 21771
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0.5	/Medical Examiner		resulting in death)	Due to (or	as a consequ	Part and a second	lletion				,
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687	ifficate g phys as the	edical		d			-		-		
Vital Records, P.O. Box	ath cer ttendin or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown		h 2∐Feta ntattime of d	I death 3[□Ectopic pregnancy □ Other (specify) _	/		23d. Date of o	letivery Day Year
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	Physic this co al dire	ပ္	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1★ Inp		ER/Outpatie	nt 3 DOA Oth	4 🔯 Nursing F		lence 6 Other (S)	pecify)
ou (ding I h. After funer	tion:	1 Natural 5 □ Pen	/A/anth	Day Year)	Injury	Wor	k? Yes 2∐No	20d. Describe n	ow injury occurred	
Division or	늘으는	Certification:	3 Suicide 6 Cou	lld not be 28e. Place of	f injury - At ho , etc. <i>(Sp</i> ec <i>if</i>		reet, factory, office		28f. Location (S City or Tow		Rural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Ce	29a. Certifier (Check only one)	fying Physician: To the be cal Examiner: On the bas and manne	is of examina	owledge, dea ation and/or i	th occurred at the ti	me, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
	o the o the o the o the o the omple	Med	29b. Signature and title of cert		JIGITU.		29c. Licens	se number		29d. Date signed (Mo	onth, Day, Year)
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1	XIM		30. Name and address of pers	on who completed cause	of death (Iten	n 23a) (Type		TIMA	PAND	EY, M	D.
	St	ate	31 Date filed (Month, Day, Ye	2//	gistrar's Signa	ature	books	,			
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State of Maryland / Department of H	ealth and Mental Hygiene 200/

	an	Decedent's Name (First, Middle, Last)	Kansa	5 L.	Lewi	2.5	2. Date of Death Month	Day 04	Year 07	3. Time of Death 04: 30
/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Aberder	r Location of Death		4c. County		
ineral rector		5. Social Security Number 6. Sex 215–34–6340	7. Age (Ir	n yrs. last birthda 82 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day, 7/4/1925	(ear)	9. Birthpl Count West	ace (State or Fore try) Virginia
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23a or 28 lat be no	al Director	10e. Street and Number 1334 Perryman Roa	ad		10f. Zip Code 21001		10	g. Citizen of \		try?
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then "natur in Mudical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Gi	cedent's Usual Occupa ve kind of work done of DO NOT use retired	ation during most of work d)	ing 1	6b. Kind of B	usiness/Ind	
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tem 27 other tr	-	19a. Informant's Name/Relationship (Type Theda M. Parks (I 20a. Method of Disposition 1 ∰Burial 2 □ Cremation 3 □ Re	Daughter) emoval from State	29 20b. Place of Dis cometery, co	Valley Bo	ettom Rd.	Aberde	en, Ma	rylan City or Tov	d 21001 wn, State
Importent: if i any njury or o once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		Harford I	Memorial G 22. Name and Addres Tarring—C	ss of Facility Cargo Fune	eral Home	, P.A.		ryland
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			For State Registrar	State of M	Maryland	l / Depa <i>Cer</i>	rtment of F	lealth <i>Death</i>	and Me		giene Reg. No.		29279
ı	Dhusisi		1. Decedent's Name (First, Middle, La	st)						2. Date of De Month	ath /Day	Year	3. Time of Death
	Physici: /Medic			arren J.		3				Lugu	51 3	31,200	
	Examin	er	4a. Facility Name (If not institution, giv		er)		4b. City, Town, or	r Location	of Death	/	- 1	County of Dea Cecil	th
_	F		Laurelwood Care 5. Social Security Number 6. S		Age (In yrs. la	st birthday)	Elkton If Under 1 Year	If Unde	r 24 Hrs.	8. Date of Bir	th	Q Riv	thplace (State or Foreign
	Funeral Director			571 M 2015	78	Yrs.	Months Days	Hours	Min.	JAN 1,	y, Year) 1929) Ma	ryland
	p ,		Usual Residence of Decedent 10a, State 10b, County		100 Ciby	Town or Lo	ation						10d. Inside City Limits
	ehov	'n					ation						1 ∑ Yes 2 □ No
	28a-f	Director	Maryland Cecil		<u> </u>	kton	10f, Zip Code				10g. Citi	zen of What C	ountry?
	death with the Maryland ome 23a or 28a-f ehow ir must be notified at		109 Gilpin Avenu	ie.			21921				U	nited S	States
	death	Funeral	11. Marital Status	12. Was Deceder		i. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic O	rigin? (Spec	cify Yes or No		14. Race - Ame Black, Whi	erican Indian,
õ	or its	y Fu	1 ☐ Never Married 2 Married	1 X Yes 2 { If Yes, Give	_{⊒No} 193.	'	Yes 2 No	Specify				Specify	
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Z	ould I Men Marke Maric	٩	William L. Loomi						y Ash		-		- 0 //
Mai	d 2 sh th and 7 ie n traun		19a. Informant's Name/Relationship (Ruth G. Loomis/W	• •			g Address <i>(Street :</i> ilpin Ave						
-	Heal Heal tem 2 other		20a. Method of Disposition	116	20b. Pla	ce of Dispos	sition (Name of patory or other place		Da	ite		cation - City or	
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'n	es the done de de	by F	Part II. Other significant conditions of	ontributing to death	but not resul	ting in the un	derlying cause give	en in Part	l.	_		/	o the cause of death?
coras,	een s	ted								10		No 3□P	robably 4 Unknown
Z E	e la hes	ompleted								24a. Was autop		24b. Were a prior to death?	utopsy findings available completion of cause of
		Co	OF Man area referred to medical							1 Yes	2.4 No	1 Yes	2 □ No
N [a	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ntient 2□E	R/Outpatient	3□ DOA Oth			Check only o		S ☐Other (Spe	ecify)
0	g Phy ier this	ı.	27. Manner of Death	28a. Date of Ir		28b. Time of Injury	28c. Injun			3d. Describe			,,
VISION	endin sath. or: Aft he fur	atio	1 Natural 5 Pending 2 Accident investigation	1		,		Yes 2]No				
Ĕ	To the Hospital or Attending Physic within 24 hours effer death. To the Funerel Director: After this ce completely filled in by the funeral dire	ertification:	3 Suicide 6 Could not b determined	289. Place of	Injury - At hon etc. <i>(Specify)</i>	ne, larm, stre	et, lactory, office		21	Bf. Location (- City or To			ural Route Number,
נ	pital ours e erel [O	29a Cartifier (XCertifying Ph	ysician: To the be	st of my know	fortun Hunth	promot at the tin	na date a	nd class as	of Ama to the	managatal	and manner a	E STMLAN
	• Hos	edical	(Check only 2 Medical Examone)	niner: On the basis and manner	of examination stated.	on and/or inv	estigation, in my o	pinion, de	ath occurre	d at the time,	date and	place, and du	e to the cause(s)
	To th To th comp	ğ	29b. Signature and title of certifier	/	_		29c. License	e number			29d. Date	e signed (Mon	th, Day, Year)
			M. Jark	as, /	TP		11/	53	14		fug	115/ 3	1, 2007
	4+1		30. Name and address of person who	completed cause o	f death (Item :	23a) (Tyge, 6	Print)	311	1. Bri.	Lac	St.	Elk	Ton, MD
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 1 2007	32. Regi	strar's Signatu	food.	فع						th, Day, Year) 1, 2007 1000, 100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

1- For Amend 25,27,28a-f, perME,g871, 9/25/07 TTT Certificate of Death

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 555 Avaust LAYTON LAWRENCE LOZON, II 2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Easton Talbo If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**▼**M 2□ F 89 FEBRUARY 6, 1918 MARYLAND Director 217-09-4329 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits show 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director MARYLAND OUEEN ANNE'S CHESTER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be UNITED STATES 604 DOMINION ROAD 21619 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 5 √ Yes 2 □ No If 7 €s, Give Year or Dates: 1945—1946 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WELDER STEEL h and Mental Hygien 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LENA P. GAMBREL LAYTON LAWRENCE LOZON, I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau 604 DOMINION ROAD, CHESTER, MARYLAND_21619 SHIRLEY R. LOZON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition AUGUST 31 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KINGSLEY CEMETERY 2007 CHESTER, MARYLAND 21. Signature of Funeral Service License FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the Nicosa, or complications — aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pheomenic /Medical Due to (or as a consequence of): THUM APPROVED BY MEDICIAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Polmeyary Diges & Pos 1 ☐ Yes 2 ☐ No Chance Obst Division or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After ti 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐No 2 Accident 3 Suicide 8/27/2007 subject fell 5:20 am 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 604 Dominion Rd. Chester, MD Learlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10053110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

13a0+1

31. Date filed (Month, Day, Year)

DENNIS DESHIELDS, M.D.

32. Registrar's Signature

219 S. WASHINGTON STREET, EASTON, MARYLAND 21601

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 Alma Theresa Lacey September /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Nursing Center St. Marv's Leonardtown 8. Date of Birth (Month, Day, Y August 19, Birthplace (State or Foreign Country) Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 X F 78 Maryland Director 217-30-6843 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a State ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 X No Funeral Director Chaptico St. Mary's Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or items 23a or: USA 20621 23910 Old Chaptico Wharf Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 XXVo Baltimore, Maryland 21215-0036 Specify Completed by White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Disabled Handicapped 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Theresa Bohle Phillip Parran Lacey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Cecil Andy Bell, Sr. / Friend 23926 Old Chaptico Wharf Lane, Chaptico, Maryland 20621 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 X Burial 2 □ Cremation 3 □ Removal from State Sacred Heart Cemetery 10, 2007 Bushwood, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 270, Leonardtown, Maryland 20650 Michael 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin To not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between caused the death Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an performed? funeral director, 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier smes cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete 24035 Three Notch Road, Hollywood, Maryland 20636 James P. √arboe, M.D. 31. Date filed (Month, Day, Year) State Registrar

				For State Registrar	State of Ma	ryland / D	epartme Certifica	ent of H	ealth and M	Mental Hy	giene 2007	29282
				1. Decedent's Name (First, Middle, Last)						2. Date of De. Month	ath Day Year	3. Time of Death
		Physici /Medio		John M. Lawler						Aug.	29 2007	5:30 A M
		Examir		4a. Facility Name (If not institution, give s.			4b. Ci		Location of Death		4c. County of Dea	th
				Atlantic General H				Berli			Worceste	
		Funeral Director		5. Social Security Number 217-56-4414 Usual Residence of Decedent	M 2□F 7. Age	(In yrs. last birth	Month		If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da March	9. Bir Co 3, 1927 NY	thplace (State or Foreign buntry)
		land ow		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
		the Marylan r 28a-f ehow notified at	Director	MD Worcester 10e. Street and Number		Berlin	10f.	Zip Code			10g. Citizen of What Co	1 ☐ Yes 2 No
2		3a or		7 Tortola Lane				21811			USA	
ŏ		ler death	Funeral		2. Was Decedent E	ver in U.S.			ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No		
81291200	920	within 72 hours after death with the Maryland ene. than "naturel", or itema 23a or 28a-f ehow ha Mudical Examinar must be notified at	by	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	∘ WWII		pecify Cuba ; 2√∏ No	Specify:	Hican, etc.)	Specify: Wh	
2/2	21215-0036	hin 72 ho 9. an "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			Decedent's U Give kind of life DO NOT	work done	during most of world	king	16b. Kind of Business	/Industry
0	21	filed within Hygiene, other then	Con		4		stems	Analy			Governmen	t
0	pu	be filed tal Hygie d other	Be (17. Father's Name (First, Middle, Last)							Maiden Sumame)	
Do	yla	should be nd Mental marked o	2	John M. Lawler, Sr		,			Mary LaB			
J	, Maryland	12 sh sh and 7 te m traum		19a. Informant's Name/Relationship (Type Shirley Lawler (wi		7 T	ortola	Lane	, Berlin		er, City or Town, State, . 1811	Zip Code)
~	ore	2 5 5 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	amayal from State	20b. Place of I	Disposition (No.), crematory of	vame of or other place	θ)	Date	20c. Location - City or	Town, State
1927	<u>Ĕ</u>	Pages ment of I ant: If Its ury or o		4 Donation 5 Other (Specify)	anioval noin State	Cape H	enlope	n Cre	m. 8-31	-2007	Frankford,	DE
330	Baltimore,	permit, Page Department of Important: If eny injury or spcs.		21. Signatur of Funeral Servic Usense	Hend		22. Name 108 W	and Addres	ss of Facility The	e Burbaç erlin, N	ge Funeral Md. 21811	Home
1801		-		23a. P. 11. Enter the disease, or com 46 stock, or heart failure. List only on Immediate Cause (Final	o lions that caused to e cause on each line	the death. Do no	ot enter the m	ode of dyin	g, such as cardiac	or respiratory ai	rrest,	Approximate Interval Between Onset and Death
0		Physician /Medical		disease or condition resulting in death)	Due to (or as a	NON IQ	f):					
1		Examiner		Sequentially list conditions.								
000		ted nsit	nine	Sequentially list conditions, if any leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a	consequence of	f)e					
Q	ó	be executed siclen and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of	f):					
7	8760,	3 2 9	dicai	d.								
sur ler	5. Box 68	The law requires that the death certificat sie hes been signed by the attending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 □Ectopio 5 □ Other				23d. Date of de Month	livery Day Year
7	<u>a.</u>	that the	/ Phy	Part II. Other significant conditions conf	tributing to death but	t not resulting in	the underlying	g cause give	en in Part I.	23e. Did to	obacco use contribute to	o the cause of death?
E,	ords	w requires been sign should be								101	/es 2 □ No 3 □ P	robably 4 Unknown
Shr	ľ Rec	The law sete hes b page 2 st	Completed							24a. Was autop perfo	osy prior to rmed? death?	utopsy findings available completion of cause of
20	Vital	certifice rector, p	Be (25. Was case referred to medical examiner?					26. Place of Dea	th /Check only o	ne)	
	of \	Physical this call dire	2	1 ☐ Yes 2 No	ospital: 1 npatien				4 Nursing H		dence 6 Other (Spe	ocify)
		ding Ph h. After th funeral	on:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day	/ 28b. Ti <i>Year)</i> In	jury	28c. Injury World		28d. Describe I	now injury occurred	
	isic	death death ctor: /	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Ogo Disea of Injur	n. At home for	M		Yes 2 □ No	20f Location (Street and Number of C	und Claute Alumba
	Division	il or Atten after deat Director: d in by the	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)	n, street, fact	огу, опісе		City or Tox	Street and Number or R vn, State)	urai Houle Number,
		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely illied in by the funeral director.	dicai	29a. Certifier (Check only one) Certifying Physical Examin	ician: To the best of er: On the basis of and manner state	examination and	death occurre /or investigati	ed at the timon, in my of	ne, date and place, pinion, death occur	and due to the rred at the time,	cause(s) and manner a	s stated. e to the cause(s)
		ro the	Me	29b. Signature and title of certifier	,		2	29c. License	number		29d. Date signed (Mon	
)	> - 0	DO 056307 August 29, 200								2007	
	f	3A 10+1		30. Name and address of person who cor	mpleted cause of de	ath (Item 23a) (T	Type, Print)	ital.	1733 Heal	4hway I	onve, Berlin,	MD 21811
		Sta Registi		31. Date filed (Month, Day, Year) AUG 2 9 200	32 Negistrar	de Cinestone	Sperke					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle, Last) 2. Date of Death Day Month Palmer Rollo Mowen **Physician** vaus + 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 19 1914 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 M 2 □ F 93 214-09-6474 Penna. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" or item any injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Penna. Franklin State Line Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 385 Reid Rd. - P.O. Box 113 17263 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Mfg. Engine Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Orpha Johnston Harry C. Mowen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
385 Reid Rd. - P.O. Box 113 State Line, Pa. 17263 19a. Informant's Name/Relationship (Type. Print) Anna R. Mowen/Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9/4/07 Greencastle, Pa. 4 □ Donation 5 □ Other (Specify) Zinmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician (01000 1 use a . 5 . c /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Ves 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient SER/Outpatient 3 DOA Yes 2□ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa and title of certifier 20056965

Registrar
DHMH 17 Rev 1/2001

State

8.

251

Registrar's Signature

mo

21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Gregg My	•	I- For State	State of Maryla		artment of rtificate of		nd Menta	Hygiene	Reg. No.	007 29	328	
Physicia	ın/	1. Decedent's Name (First, Mid						2. Date of D Month	Day Year	3. Time of Death 2023 hrs	h	
Medical Examin		Seeven dregg myers							September 5, 2007			
4		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deal 226 Smoot Street Westernport							Allegany	334		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Y	ear If Under 2	4Hrs. 8. Date of	Birth (MM/DD/YYYY)	9. Birthplace (State or		
Director	j	295-58-7283	1X M 2 F	48	Yrs.		ays Hours	Min. 3-22-	- 1959	Foreign Country) WV		
geraphic Sugardon provide the Rept of S. S. Co.		Usual Residence of Decedent									1.1.11	
w any		10a. State 10b. Count	1		, Town or Location					10d. Inside City 1 Yes 2		
ith the Maryland 23a or 28a-f show notified at once.	ē		gany	We	sternpo				10g. Citizen of Wha		AINO	
Mary r 28a	Director	10e. Street and Number				10f. Zip Code			log. Citizen of white	it Country?		
aiter death with the Maryland an", or items 23a or 28a-f she mer, must be notified at once	밁	226 Smoot St		cedent Ever in U	IS 13 Was	2.15 s Decedent of	62 Hispanic Origin	(Specify Yes or	No- 14. Race	A - American Indian, Black	k,	
ath w items	uner	1 Never Married 2 X	Married Armed F	orces?	If Ye	es, specify Cub	an, Mexican, P	uerto Rican, etc.)	White		EW.	
fter de	ᄔ	3 Widowed 4	1 Yes Divorced If Yes, Give Yea	2 X No	1	Yes 2 X	No specify:		Specify:	white		
ours a atura	od b	15. Decedent's Education (S	pecify only highest gra	de completed) .	. 16a. Deceden	t's Usual Occup	pation (Give kin	d of work done e retired)	16b. Kind of Bus		20.00.21	
6 172 h	ete	Elementary/Secondary (0-1)	2) College (1-4 or 5+)			~~				٠	
15-0036 filed within I Hygiene. ed other tha	Completed		lle Leet)		Certif	ied Liv	ing Ass		e, Maiden Surname)	s Aware		
1215-0036 The filed within 72 ental Hygiene. rked other than ent, the Medical	BeC	17. Father's Name (First, Midd Robert Winfi	•					lis Camp				
C B Z E S	ToB	19a. Informant's Name/Relatio			19b. Mailing	Address (St	reet and Number	r or Rural Route.	Number, City or Towr	, State, Zip Code)	.*	
MD d 2 sho lith and u 27 is		Phyllis Myers	/mother		450 Se	erene D	r Wat	erloo. S	C 29384			
Baltimore, MI peneit, Pages 1 and 2 s De sartment of Health as Important: If item 27 injury or other traum		20a. Method of Disposition			Place of Dispos crematory or oth	ition (Name of	cemetery,	Date	20c. Location -	City or Town, State		
MOP Pages ent of ent: II		Burial 2 Cremat Denation 5 Other	-		rnolli Fi	meral Ho	me. PA	9-5-200	7 Cresa	ptown, MI	D	
Baltimore, pen it Pages I at De artiment of Hee Important: If ite	- rants	21. Signature of Funeral Servi		1/1/	22. N	lame and Addr	ess of Facility C	arpell:	i Funera	1 Home, P	'A	
0 80 5 5 5		1/////	TUN	Wi.	10	o virgini	la Avenue	, cumberla	na, MD 21502			
Physician /Medical xaminer	4	23a. P. in I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart nilure. List only one caus on each line. In rediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Approximate in Between Onse Death Due to (or as a consequence of):										
ecuted and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
), be ex sician urial	dical	UNPENDED	AMENDED									
Ox 6876(ath certificate attending physoruse as the b	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 1	n the 1 Live	nant at time of d	2 Fe	etal death ther (Specify)	3 Ectopic p	regnancy	23d. Date of Month		ear	
s, P.O. Be in rest that the defined by the defined by the defined by the defined by the defined for the define	δ	Part II. Other significant con	ditions contributing	to death but not	resulting in the t	underlying caus	se given in Part			bute to the cause of dea		
of Vital Records, ng Physician: The law require. Nfer this certificate has been simeral director, page 2 should t	Completed							p	utopsy performed? c	Vere autopsy findings a prior to completion of calleath? Yes 2		
tal Rec cian: The l certificate ector, page	au l	25. Was case referred to med examiner?				26.PI	ace of Death (C	heck only one)				
Vit hysici this c	To B	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient			Nursing Home 5				
n of ding Ph After t		27. Manner of Death 1 ✓ Natural 5	(Mont	e of Injury h, Day,Year)	28b. Time of	′′ I _	njury at Work? Yes 2 N	1	ibe how injury occurr	ad		
Division Spital or Attendit hours after death. meral Director: A	Certification:		ending evestigation						on (Street and Numb	or or Pural Poute Numb	ner City	
Divisipital or At a pital or At a cral birect filled in by	ıţį.	2 Accident and Number or Rural Route Num 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Num or Town, State)							a of Rural Route Numb	/ei, City		
D Hospital 24 hours Funeral tely fillec	ပို	4 Homicide	g Physician: To the be		dan dooth occu	ered at the time	date and place	and due to the	cause(s) and manner	as stated		
	edical	(Chart ant)	xaminer: On the basis	of examination	and/or investiga	ition, in my opir	nion, death occu	rred at the time, o	late and place, and d	ue to the cause(s)		
To the within.	Med	29b. Signature and title of cer	and manner tifier	stated.		29c. Lic	ense number		29d. Date sign	ed (Month, Day, Year)		
		O.C.M.E.						September 4, 2007				
		30. Name and address of pers	son who completed car	use of death (Ite	m 23a)							
5		Ana Rubio MD. A	Assistant Medical	Examiner	111 Penn \$	Street, Balti	more, MD 2	1201				
Panis	tate trar		W.	Registrar's Signa		11						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 29285

		For State		Certificate of	of Deat	h		D D-1 1 D	Reg. No		3, Time of Death	
Physician	/ 1:	egistrar 1. Decedent's Name (First, Middle,Last) Norma Lee Moore						2. Date of D Month Septem		Year 2007	1920 hrs	
Examin		a. Facility Name (if not institution			ocation of De	eath		c. County of De Dorchester				
		204 Smith Street				bridge ler 1 Year	If Under 24	Hrs 8 Date of			Birthplace (State or	
Funeral	ı.	Social Security Number		In yrs. last birthday)	Mont			Min. July		Fo	oreign Country) MD	
Director	1	213-22-7231	1 M 2XF	82 Y	rs.		4 /	pury	24,	. 1923		
, Lieu A	-	Sual Residence of Decedent Oa. State 10b. County	, [1]	Oc. City, Town or Loc	ation			1111			10d. Inside City Limits	
ow any			chester -		Ca	mbrid	lge	100			1 X Yes 2 No	
Maryland 28a-f show d at once.	휭	0e. Street and Number		4	10f. Z	p Code	100		10g. C	itizen of What	Country?	
or 28	Director	204 Smith Str	reet				21613			USA	Land Dienk	
death with the Maryland or items 23a or 28a-f sho		1. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Nas Dece	dent of Hisp	anic Origin? Mexican, Pu	(Specify Yes o lerto Rican, etc.)	r No-	14. Race - A White, e	merican Indian, Black, tc.	
r ifen	Funeral		1 Yes 2	K No		2 X No		100		Specify: white		
after	ð	3 X Widowed 4 Di 15. Decedent's Education (Spe	ivorced If Yes, Give Year or Dates:	ileted) 16a, Dece	dent's Hsu	al Occupati	on (Give kind	d of work done	161	. Kind of Busin	ess/Industry	
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	절	15. Decedent's Education (Spe Elementary/Secondary (0-12)		during	most of v	orking life.	DO NOT use	e retired)		10	etail	
36 Jin 72 Lihan tihan dical	Completed	11	,		sa.	les c						
5-0036 iled within 72 Hygiene. d other than	탉	17. Father's Name (First, Middle	le, Last)					Name (First, Mid McColl				
21215 uld be file Mental H marked c	<u>@</u>	Hamilton Ma		Liou	iliman Antolog	oo (Stroo	.EVa	MCCOLL	Number	. City or Town,	State, Zip Code)	
D 2121(should be fill and Mental F 77 is marked	우	19a. Informant's Name/Relation		3514	I Tnd	ian C	reek R	d. Eas	t Ne	w Marke	et, MD 21631	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shu other traumatic event, the Medical Examiner must be politifed at once	-	Wayne Marsha. 20a. Method of Disposition	11 neph	20b Place of Dis	position (lame of ce	metery,	Date	. 20	oc. Location - C	ity or Town, State	
of He	- [1 X Burial 2 Crematic	ion 3 Removal from Sta	crematory of Dorchest			ark	9/8/07		Cambrid	lge, MD	
Baltimore, bermit. Pages I at Department of Her Important: If ite	ļ	4 Donation 5 Other 21. Signature of Funeral Service	Specify:	DOLCTIES	2. Name a	nd Address	s of Facility	Thomas	Fune	ral Hon	ne P.A.	
Baltimore, ML permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	- 1	11 . 6 1			700	Locus	+ S+	Cambri	dae.	MD 21	613	
ysician	\dashv	23a Part I Enter the disease.	or complications that caused	the death. Do not en	ter the mo	e of dying	, sưch as care	diac or respirato	ry arrest,	shock, or hear	Between Onset and Death	
Medical	1	failure. List only one cause Immediate Cause (Final disease	_{ase a Head injurie}				241				Deali	
Examiner		or condition resulting in death)	Due to (or as a conse	equence of):			ete str					
	_	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conse	equence of):								
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isi d	Exar	events resulting in death) Las	Due to (or as a conse	equence or):								
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760, ficate be exe g physician a	/Medical	IF FEMALE:	23c. If yes, outco	me of pregnancy						23d. Date of	delivery Day Year	
		23b. Was decedent pregnant in past 12 months?	in the 1 Live birth	2	Fetal de		Ectopic	pregnancy		Month	Day	
Box 6 e death cer the attend ed for use	sician	1 Yes 2 No 9 🗸		t time of death 5	_ Other (Ѕреспу)						
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ds, equire een si	Completed							248	. Was ar autops	y p	vere autopsy findings available prior to completion of cause of leath?	
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/ita //ysicial his cer directe	O B	examiner?	Hospital: 1 Innat		atient 3	DOA	Other ₄	Nursing Home	h	Residence 6 Now injury occurr	Other: Scene	
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Divis	S	4 Homicide 29a. Certifier 1 Certifyin	1,27	residence	occurred	at the time	, date and pla	acc. and due to	he cause	e(s) and manne	r as stated.	
£ 4 g a	Medical	(Check only one) 2 Medical	I Examiner: On the basis of ex	amination and/or inv	estigation,	in my opin	ion, death oc	ccurred at the tin	ne, date a			
To the I within 2 To the I complete	Med	29b. Signature and title of ce	and mariner state	u			ense number			29d. Date sigr	ned (Month, Day, Year)	
		his	hi, m	7		0.	C.M.E.			Septembe	7 6, 2007	
		30. Name and address of pe	erson who completed cause o	f death (Item 23a)			- MD 044	201				
		Ling Li, MD Ass	sistant Medical Examir	ier 111 Penn	Street,	Baltimor	e, MD 212	201				
	Stat		19 2007 32. egis	trar's Signature	Ann	80						
Reg			OCME	OPI	GINAL							
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State of Maryland / Department of Health and Mental Hygiene 2007

1 - For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** 4:30 PM BARBARA HEBDEN MASON AUGUST 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1905 RUTHSBURG ROAD **OUEEN ANNE** QUEEN ANNE'S Il Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JULY 18, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 TF 227-24-0698 MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ir than "natural", or items 23e or 28a-f ahow If a Medical Examinat must be notified at 1 Yes 2 No MARYLAND QUEEN ANNE'S QUEEN ANNE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1905 RUTHSBURG ROAD UNITED STATES 21657 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) mit. Pages 1 and 2 should be fili partment of Health and Mental Hy portent: If Item 27 is marked oth y injury or other treumatic event Be ပ ROLAND HEBDEN BEATRICE NAU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM I. MASON/HUSBAND 1905 RUTHSBURG ROAD, QUEEN ANNE, MARYLAND 21657 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State SEPTEMBER 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) CHESTERFIELD CEMETERY 2007 CENTREVILLE, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A 21. Signature of Funeral Service Licensee 408 S. LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Small (ell ung 11on /Medical Examiner orman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consec ience of) Examine ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ete hes been signed | page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No pertension certificate 1 ☐ Yes 2 No or Attending Physician: After this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury Natural s efter decreal Director: Alte 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide within 24 hours e. To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. 29a. Certifier Medical (Check only one) physician 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number H005782 29/07 LP eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 10 , Contraule, MD Centreville Ruad Gooding 2540 DO 31. Date liled (Month, Day, Year) 32. Registras's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Department of State of Sta			, ,	Iene eg. No. 2 N	07	29287			
E	Director		1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month	h Day	3. Time of Death				
	Physicia /Medic		Frederick K. Mack	A			22, 20	2, 2007 5:26 P ^M				
	Examin	er		City, Town, or Location of Death			4c. County		-1			
	· -		Anne Arundel Medical Center Annap 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		f Under 24 Hrs.	8. Date of Birth	Anne Arundel					
	Funeral Director		5. Social Security Number 063–18–5707 6. Sex 2 F 83 7. Age (In yrs. last birthday) Months 1 Months 1	Days	Hours Min.	July 5,	1924	New .	ce (State or Foreign /) York			
7	put		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d	I, Inside City Limits			
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	the N	Director	Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip C	Code		1	0g. Citizen of V	Vhat Country				
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	ems :	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Forces? 13. Was Decedent Forces? 15. Was Decedent Forces?		anic Origin? (Spe Mexican, Puerto		14. Race	e - American	Indian,			
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	nd 2 should be fil Ith and Mental H 17 is marked ot 17 is marked ot	Be	17. Father's Name (First, Middle, Last) Edison D. Mack		Grace Pa	, ,	vialuen Surnam	ie)				
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Ž	alth a 27 is 27 is		Ann S. Mack / Wife 19 Second	Stre	et Anna	polis,	Mary1an	d 2140	01			
baltimore,	es 1 a of He of He fitem		20a. Method of Disposition 20b. Place of Disposition (Name cemetery, crematory or other	e of ner place)		ate	20c. Location -	City or Town	n, State			
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ם	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.				of Facility Joh Glouces				Home, Inc.			
									Approximate			
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition									
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Ξ.	certificanding plans as the	Med	IF FEMALE: 230 If year outcome of programmy									
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ν, T	requires that the een signed by th rould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given	in Part I.				cause of death?			
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Š	2 38 8	Completed			•••	24a. Was a autops perfor	sy	Were autops prior to comp death?	sy findings available of cause of			
Ig	ician: The certificate ha rector, page		25. Was case referred to medical		OC Pierr of Death	1□ Yes	2	1 ☐ Yes 2	Bye			
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5	ding Physician: After this certific funeral director,	⊒:u	27. Manner of Derith T☐Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury 28c. State of Injury 28c. Time of Injury 28	c. Injury a Work?		28d. Describe h						
sion	tendii eath. tor: A the fu	catic	2 Accident investigation M		es 2 No							
<u> </u>	pital or Attendous after deathers after deatheral Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined 4 ☐ Homicide determined building, etc. (Specify)	опісе	ice 28f. Location (Street and Number or Rural City or Town, State)			er or Hurai i	Houte Number,			
	the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica mpletely filled in by the funeral director, I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at									
	the Hos in 24 hc the Fun ipletely	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, i and minner stated.			red at the time, o	date and place,	and due to t	the cause(s)			
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)			30. Name and address of person who completed cause of gleath (Item 23a) (Typt), Prigit),		1) 1 1	01 11	0/24	1	1			
15	HICH	^	30. Name and address of person who completed cause of death (filem 23a) (1996, Print)	al P	arkway,	Annapol	ed is, MD	21401	Hen			
	Sta		31. Date filed (Month, Day, Year) 32. Refistrar's Signature		, .	•						
	Registr	ar	AUG 2 4 2007 Men & Spark									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUGT **Physician** Vernon Michael Matrese 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE BALTIMORE WASHINGTON MBDIZAC LEN BURNIE NTER If Under 24 Hrs. Social Security Number 177–22–6731 If Under 8. Date of Birth **Funeral** Days Months Hours 11/13/1932 PÃ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 27s and 1 in any in Jury or other trainmain. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits MD Anne Arundel Odenton 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 546 Maple Ridge Lane 21113 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Named Poices?

Named Poices?

No 1952

If Yes, Give
Year or Dates: 1955 1 Never Married XXMarried 1 ☐ Yes 2000 No White à Specify: 3 ☐ Widowed 4 ☐ Divorced 1955 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Analyst NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Matrese Mary Dora Naples ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 546 Maple Ridge Lane Odenton, MD 21113 Audrey Matrese Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Crownsville Md Vet 08/27/2007 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ser ce Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFAIZETIONS **Physician** Acies MYDEAZSIAE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9□Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number

Registrar

31. Date filed (Month, Day, Yea **AUG 27** 327Registrar's Signature

completed cause of death (Item 227) (Type, Print)

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0	Physici	an	1. Decedent's Name (First, Middle, Last) Marilyn Elizabeth		Ma+h				Date of Death Month	Day Y	ear	3. Time of Death
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	Examin	er	24775 Sotterley Road				ywood	Jean		St.		y's
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936	urs af al", or Exami	b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		1	☐ Yes 2 No	Specify:			Specify:	Whi	.te
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ar Z		7	19a. Informant's Name/Relationship (Type. Print)	19	b. Mailing	g Address (Street a			s Knigl loute Number,		ate, Zir	Code)
	is 1 and 2 of Health a Item 27 is other tra		Gary J. Meekins/ Husband	24	4775	Sotterle	y Road	, Ho	11ywood	i, Maryl	and	20636
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place		ition (Name of natory or other plac		Date		0c. Location - C		
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Ba	permit. Pages Department of Important: If It any Injury or o once.	3 B	21. Signature of Funeral Service Licensee Kyle S. Simons M01206	>un	- 22. B 22	Name and Address rinsfiel 1955 Holl	s of Facility d Fune: ywood	ral l	Home, P Leonar	A.	Mar [.]	yland 20650
2	* **		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	i the death. Do								Approximate Interval Between
	Physician		Immediate Cause (Final disease or conditiona,CARC	NOMA	0	FQ	BRKAS	T			-1	Onset and Death
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ord	w require been sig should b	ted						-	1 🗌 Yes	s 2)⊠ No 3	☐ Prob	ably 4 □Unknown
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Division or	g Phys er this eral dii	7: To	27. Manner of Death 28a. Date of Inju	ıry 28b.	Time of	3 DOA 28c. Injury Work	4 LI Nursir			nce 6 Other)
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	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	it examination a	ge, death ind/or inv	estigation, in my of	ne, date and p pinion, death o	occurred	due to the car at the time, da	use(s) and manr te and place, an	er as si	ated. the cause(s)
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			Mobert 1 B aves	mo		Do	014168	\$		9-4-	07	
			30. Name and address of person who completed cause of c	eath (Item 23a)	(Type, P	Print)	.1 0.	CI.	101 0	16	٠,	MI
	Sta	te.	Robert J. Bauer, M.D. 31. Date filed (Month, Day, Year) 32. Registr	2 810 3 ar's Signature	1h	ree 110to	ch Kd.	, ste	101 111	echanics	VIlle	Md. 20659
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State of Maryland / Department of Health and Mental Hygiene 207, per FHDR, HCHD riffe ate of Death 29290 1- Statemend#18, 8-29-07, per FHDR, HCHDriffcate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day August 21, 2007 Joseph Elwood Miranda 1:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Ohio 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** 1(XM 2□ F Yrs. 75 Director 277-30-6578 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or iteme 23e or 28a-f ehow ent, the Medical Examinar must be notified at 1 X Yes 2 No Director DC Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4545 Connecticut Avenue, NW #1028 20008 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (2) Yes 2 □ No I Yes, Give Year or Dates: 1957-61 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: USA Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Copy Writer Library of Congress es 1 and 2 should be filed vol Health and Mental Hygis of Health and Mental Hygis if item 27 is marked other in other treumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Audrien Be VanWinkler VanWinkle Elwood Cooper Miranda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 is 259 Crosswell School Rd. Easley, SC 29640 Martha Miranda Miller/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of F ent: if ite Depertment of importent: if it is eny injury or one 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 08/23/07 4 □ Donation 5 □ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to innectiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2. No Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certific completely tilled in by the funeral director. 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Basino 00057124 9/21/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 MEDICAL CENTER DR. #201 ROCKVILLE, MO TRUON G 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State Registrar AUG 2 9 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ам 26, 2007 7:35 Marv В. Maiers August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3005 S. Leisure World Blvd., #217 Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 T F Director 165-20-2228 95 Nov. 5, 1911 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □ Yes 217 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3005 S. Leisure World Blvd., #217 USA Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2√√No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 h (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Principal Education permit. Pages 1 and 2 should be filed Deparlment of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, til 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ithel Raymond Betterly Catherine O'Neill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 2090€ Kathryn M. Maiers/Daughter 3005 S. Leisure World Blvd., #217, Silver Spring, Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept Date 1 € Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W. Silver Spring, 21. Signature of Funeral Service Licensee Ken Stile MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myccardial Infarction Due to (or as a consequence of): Minutes /Medical Examiner Coronary Artery Disease
Due to [or as a consequence of]: Sequentially list conditions, if a y leading to hime fall cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Examiner certificate be executed Senility and Due to (or as a consequence of): Box 68760. Physician/Medical as the detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 2 □ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate Vital 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) d38457 August 27, 2007 30. Name and addre ss of person who completed cause of death (Item 23a) (Type, Print) 3801 International Drive, #211, Silver Spring, MD 20906 Goyal, M.D. Nakul 31. Date filed (Month, Day, Year) AUG 28 2007 State Registrar

07-06600 Charles Moore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		- For State Certificate of Death		g. No.	
Physicia		1. Decedent's Name (First, Middle, Last)	Date of Deat Month	Day Year	3. Time of Death
ledical Examin		Charles Hugh Moore	August 25	, 2007	1642 hrs
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of D	eath
		Atlantic General Hospital Berlin		Worcester	*
Formul		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birt	h(MM/DD/YYYY) 9	Birthplace (State or
Funeral Director	- 1	Months Days Hours Min.	11-13-		Country) USA
Director		217-54-1880 1XM 2F 5/ Yrs.	11-13-	49	USA USA
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shov	5	MD Wicomico Salisbury			
Maryland 28a-f show any d at once.	ᅘ	10e, Street and Number 10f. Zip Code	11	0g. Citizen of What	Country?
death with the Maryland or items 23a or 28a-f sho must be notified at once	Director	600 W. Railroad Ave., Apt. 2 21804	UP.	USA	
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215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. ked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	8	during most of working life. DO NOT use retired	d) ·		
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21215-0036 Mental Hygiene. marked other than	æ	Harold Moore Marie De			Note: The Order
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MD nd 2 sho alth and m 27 is		Karen Sue Coulbourne (sister) 10523 Keyser Pt. Rd.,	Ucean	City, Mo	. 21842
ore, M ss 1 and 2 of Health If item 2		Zod. Mictilod of Disposition	Date	20c. Location - Ci	ty or Town, State
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Baltimore, permit. Pages I and Department of Heal Important: If iten		108 William St., Be	rlin	Md 21811	Tione
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Physician /M dical		failure. List only one cause on each line.			Between Onset and Death
kaminer	ì	Immediate Cause (Final disease a. Atherosci rotic Cardiovascular Disease			
Adminio.		or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, b.			
	<u>ē</u>	If any, leading to immediate Due to (or as a consequence of):			
-	Examiner	(Disease or injury that initiated			
nsit red	۱Ä	events resulting in death) Last Due to (or as a consequence or).			
760, icate be executed physician and the burial - transit	평	UNPENDED AMENDED	-		
D, be e	n/Medical			23d. Date of de	divery
8760, tificate being physicias the buri	ξ	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy	icv	Month	Day Year
68 Certif	ā	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (Specify)	-,		
Box 687 re death certificathe attending	ŝi	1 Yes 2 No 9 Unknown g Unknown			
cords, P.O. Box 6 (av requires that the death cornabae been signed by the attending a should be detached for use	Physicial	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribu	ite to the cause of death?
that the detac	ð	Takin siis sig	1 Ye	s 2 No 3	Probably 4 Unknown
S, F uires n sign	pa		24a. Was	an 24h We	re autopsy findings available
rd v req shoul	et		auto	psy pri	or to completion of cause of
€CC ie lav te ha	崩				ath? ✔ Yes 2 No
	= 1		1 ✓ Yes		
T. ing. T.	Completed	26 Place of Death (Check or			
ital Reco ician: The law s certificate has	å	examiner? Hospital: Inpatient 2 FR/Outnatient 3 DOA Other	nly one)		Other:
f Vital R. Physician: T er this certifice ral director, ps	To Be Cor	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing	nly one) Home 5	Residence 6	
n of Vital R. ling Physician: T After this certifica funeral director, ps	To Be	examiner? 1 Ves 2 No 28a. Date of Injury (Month, Day, Year) 1 No Notwell 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work?	nly one) Home 5		
ion of Vital R. trending Physician: T. leath. tor: After this certificative funeral director, ps.	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other,4 Nursing 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 1 Yes 2 No 1 Yes 2 No	nly one) Home 5	Residence 6 how injury occurred	
vision of Vital R. or Attending Physician: T. Rer death. Director: After this certifica in by the funeral director, p.	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other; 1 Nursing 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	nly one) Home 5	Residence 6 how injury occurred	
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Division of Vital R Hospital or Attending Physician: T 14 hours after death. Funeral Director: After this certifica ely filled in by the funeral director, ps	Certification: To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other; 1 Nursing 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and of the course of	nly one) 1 Home 5 28d. Describe 28f. Location or Town,	Residence 6 Reside	or Rural Route Number, City
Division of Vital R the Hospital or Attending Physician: Thin 24 hours after death. The Funeral Director: After this certifican pletely filled in by the funeral director, particular of the funeral director, particular d	Certification: To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other; 1 Nursing 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Medical Examiner; On the basis of examinating and/or investigation, in my opinion, death occurred at	nly one) 1 Home 5 28d. Describe 28f. Location or Town,	Residence 6 Reside	or Rural Route Number, City
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Division of Vital R To the Hospital or Attending Physician: TI within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Certification: To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA Other; 1 Nursing 27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and or investigation, in my opinion, death occurred at and manner stated.	nly one) 1 Home 5 28d. Describe 28f. Location or Town,	Residence 6 (Street and Number State) Juse(s) and manner are and place, and duce 29d. Date signed	or Rural Route Number, City s stated. e to the cause(s) I (Month, Day, Year)
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To the Hospiral or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificat completely filled in by the funeral director, page 1	Certification: To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 Verify Properties 1 Inpatient 2 Verify Properties 2 No Other, Aurising 2. Accident 2. Accident 3 Suicide 6 Could not be determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at land manner stated. 30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner: 111 Penn Street, Baltimore, MD 212	nly one) Home 5 Recorded to the catter that the time, date	Residence 6 (Street and Number State) Juse(s) and manner are and place, and duce 29d. Date signed	or Rural Route Number, City s stated. e to the cause(s) I (Month, Day, Year)
BAZ	Medical Certification: To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 Very ER/Outpatient 3 DOA Other; Nursing 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and cone) 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated. 30. Nane and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	nly one) Home 5 Recorded to the catter that the time, date	Residence 6 (Street and Number State) Juse(s) and manner are and place, and duce 29d. Date signed	or Rural Route Number, City s stated. e to the cause(s) I (Month, Day, Year)

292	9	3
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	Physici		1. Decedent's Name (First, Middle, La: GLADYS ELISABETH			rtificate of		2. Date of Death Month AUGUST	Day	Year 2007	3. Time of Death 10:00 AM
	/Medic Examin		4a. Facility Name (If not institution, give		пск	4b. City, Town,	or Location of Death	AUGUSI	4c. Count		10:00
			CORSICA HILLS NUI	RSING HOME		CENTRE	VILLE		QUEE	N ANN	
	Funeral Director		214-20-3410	ex 7. Ag	95 Yrs.	Months Days		8. Date of Birth (Month, Day,	Year) 1912	9. Birthp Cour MAR	lace (State or Foreign htry) YLAND
	M ™		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
:	9-fah	tor	MARYLAND QUEEN A	ANNE'S	QUEENSTO	WN.					1 ☐ Yes 2 X No
3	or 284	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Cour	ntry?
	3 23e	rai	100 NASH DRIVE			21658			NITED		
20	S. Faint and Montal Hygione. Health and Montal Hygione. If Paint and Montal Hygione. Item 27 is marked other than "natural", or Items 23e or 28e-f ahow other traumatic event, the Modical Examinar must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 X No	Hispanic Origin? (Spe ban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	Special	ce - Americ ick, White, ^{fy:} WHI	etc.
21213-0030	n "natura Nodical E	Completed I	15. Decedent's Ed (Specify only highest gra	l ducation de completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of worki	ing	16b. Kind of E		
7 7	giene. erthan "	Com	Elementary/Secondary (0-12)	College (1-4or 5		EMAKER			OWN	HOME	
2 3	Mental Hygi arked other atic event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			пе)	
Maryland	marke marke	2	FRANK P. ANTHONY 19a. Informant's Name/Relationship (Tvne. Print)	19b Maili	na Address (Stree	ANNIE E	LISABETH		State Zin	Code
\$ 3	alth and 27 is my r traumy		ROBERT E. NASH, I			-	Æ, QUEENS				,
saitimore,	of Hei		20a. Method of Disposition 1 By Burial 2 □ Cremation 3 □		20b. Place of Dispo				20c. Location		
Ĕ	ment tant: I jury o		`4 ☐Donation 5 ☐ Other (Specific	v)	WOODLAWN M		RK 2	007 E	ASTON,		
Da	permit. Prages I arror Department of Health a Important: If item 27 is any injury or other training.		21. Signature of Funeral Sovice Licer	70	~ 10	JO SHAMKO	OCK ROAD,	CHESTER,	MARYL	NERAL AND 2	HOME, P.A 1619
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that eaused one cause on each lir	10.		ing, such as cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death
	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Kesp	traing to	isture.					days
	xaminer			Due to (or as	a consequence on:						weeks
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	a consequence of):						WHAT -S
	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
00/00	g physician and as the burial-transit		your double party and the part	Due to (or as	a consequence of):						
5	phys as the	edicai		d							
Y	ending r use a	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnanc	*V			ite of delive	*
. 7	ed by the attendir detached for use	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at 9☐Unknown		Other (specify)	.,,		Me	onth	Day Year
ָר בְּיִּ	ad by detach		Part II. Other significant conditions c	ontributing to death bu	ut not resulting in the u	nderlying cause g	ven in Part I.	23e. Did tob	acco use con	tribute to th	e cause of death?
or vital Records,	signed I	Completed by	Dementia						s 2□No		
5	as been si 2 should	plete						24a. Was an		Were auto	psy findings available
Though	ate has	L Com						autopsy perform	ed2	prior to cor death? 1 Yes	npletion of cause of 2□ No
OI VICE	is certilicate ha	Be (25. Was case referred to medical examiner?	11. 5.1			26. Place of Death	(Check only one	7)		
5	this c	. To	1 ☐ Yes 2 € No 27 Manner of Death	Hospital: 1 Inpatie			her: Nursing Hor	ne 5 Resider			")
NISION A	th. : After s huner	tion	Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) Zoo. Time o	Wo	rk?]Yes 2 □No	200. Describe no	w injury occur	ieu	
DIVISION OF	Dir	Certification:	3 Suicide 6 Could not be determined		iry - At home, farm, str (Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Numi State)	ber or Rura	l Route Number,
To the Heaville of	within 24 hours To the Funeral completely filled	Medical (29a. Certifier (Check only one) Certifying Ph	ysician: To the best of niner: On the basis of and manner sta	of my knowledge, deatle examination and/or in ted.	occurred at the t vestigation, in my	ime, date and place, a opinion, death occurre	and due to the ca ed at the time, da	use(s) and m te and place,	anner as st and due to	ated. the cause(s)
,	withir comp	Ž	29b. Signature and title of certifier	Mus		29c. Licen	se number	29	d. Date signe	d (Month, I	Day, Year)
	P		1111	/ NA		De	75953 15 Lane,		8.0	8,0	1
1											
(5		30. Name and address of perso o	completed cause of de	eath (Item 23a) (Type,	Print)	11 Jane	Factor	Mi	21	601

1 - For State Registrar

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

MEMORIAL

5. Social Security Number

004-22-0117

STRATTON E. NICHOLS

4a. Facility Name (If not institution, give street and number)

1405PITAL

7. Age (In yrs. last birthday)

77

6. Sex 1 X M 2 ☐ F

	ow ow	ŀ	10a. State 10b. County		10c. City, Tov	vn or Location					10d. Inside City Limits
:	Mary Ff sho	ţċ	MD TA	LBOT		EASTON					1 ☐ Yes 2☐ No
.:	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Co	untry?
	h with		29885 HILLARY A	VE.		21	.601			USA	
	ems a	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of I If Yes, specify Cub	- Hispanic Origin? (S an, Mexican, Puer	Specify Yes or Norto Rican, etc.)	0- 14	4. Race - Ame Black, White	
900	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by	1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	1 X Yes 2 ☐ I If Yes, Give Year or Dates:	No	1 □ Yes 2 X No				Specify: WHI	
	in 72 ho "natur ledical I	Completed	15. Decedent's (Specify only highest of	rade completed)		a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of wo	orking	16b. Kind	d of Business/	Industry
717	led with lygiene. ner thar nt, the N		Elementary/Secondary (0-12)	College (1-4or 5	5+)	OWNER	10 Mathava No.	me (First, Middle		STAURAN	T
ם כ	ould be filed with Mental Hygiene. arked other thar atic event, the M	To Be	17. Father's Name (First, Middle, La. EDGEL NICHOLS	ST)				EFFIE TA	-	•	
Wal y	s 1 and 2 should be filed within 72 hours after death with the Marylan if Healinth and Mental Hygiene. The fire marked other than "natural", or items 23a or 28a-f show tem 21 s marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship ALCMENE V. NICHO		I	b. Mailing Address (Street 9885 HILLARY					• '
. ע	Health Health tem 27		20a. Method of Disposition		20b. Place	of Disposition (Name of	1	Date	,	ation - City or	
5	Pages ment of F ant: If ite ury or of		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		1	ery, crematory or other pla D CEMETERY		27/2007	OXF	ORD, MA	ARYLAND
Dall	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Lic	ensee	l	FELLOWS,	HELFENBE	IN & NE	WNAM I	FUNERAI	HOME PA
Ü			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each li	the death. Do	not enter the mode of dyi	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
F	hysician		Immediate Cause (Final disease or condition resulting in death)	-		ratic Ca	rdio vasc	v/m di	JEAN		3 years
	/Medical Examiner		resulting in assum	Due to (or as	a consequence	e of):					·
rd.	pit sit	iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	а солвершено	s off).					
,	execute n and ial-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence	e of):					
00/00	ate be hysicia the bur			d							
YOU	n certific nding p use as	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy	-	-		23	3d. Date of del	ivery
5	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1⊡Live birth 4⊡Pregnant a 9⊡Unknown		th 3 □Ectopic pregnand 5 □ Other (specify) _				Month	Day Year
ŗ.	es that t gned by be detad	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting	in the underlying cause gi	ven in Part I.				the cause of death?
cords,	require een siç	ted I						1	Yes 2]No 3∏Pr	obably 4 onknown
ב	0 - 0	Completed			-			per	opsy formed?	prior to death?	utopsy findings available completion of cause of
	an; The rtificate	Be Co	25. Was case referred to medical				26. Place of De	1 Yes eath (Check only		1 □ Yes	2 ■ No
>	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpati	ent 2 ER/C	dipatient 3 DOA		Home 5□Res	sidence 6	□Other (Spe	cify)
5	ding Pl h. After tl funera		27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident investigat	28a. Date of Inju (Month, Da	ury 28b ny Year)	. Time of 28c. Injury Wo	iryat irk?]Yes 2 ∐ No	28d. Describe	how injury	occurred	
	To the Hospital or Attending Physician; within 24 hours are dealed. To the Funeral Director. After this certification of the Funeral director, the funeral director, completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d [28e. Place of III]	ury - At home, tc. (Specify)	farm, street, factory, office			(Street and own, State)	Number or Ri	ural Route Number,
	Hospita 24 hours Funeral rtely fillec	Medical C			of examination a	ge, death occurred at the t and/or investigation, in my					
	To the within 2 To the comple	Mec	29b. Signature and title of certifier		/	29c. Licen	se number		29d. Date	signed (Mont	th, Day, Year)
)			Truly //	anto	o me	2 100	31466		8/	20/0	7
10	AV+		30. Name and ordress pers when LUDWIG J. EGLSI	o completed cause of C EDER . TIT M	·	(Type, Print) CYNWOOD DR.	. EASTON	J. MD 21	601		
	Sta Registi		31. Date filed (Month, Day, Year)	32 Aegist	rar's Signature	diant .	,		<u> </u>		
DHN	MH 17 Rev 1/2		5,000		20	7					
						ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2007

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

EASTON

2. Date of Death Month

AUGUST

8. Date of Birth (Month, Day, Year)
NOV. 28, 1929

29294

1448 M

9. Birthplace (State or Foreign Country)
MAINE

2007

4c. County of Death

TALBOT

State of Maryland / Department of Health and Mental Hygien 2007 29295 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Maurice Stephen Newman SEPTEMBER 2007 6:30 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours 76 227-34-0215 Feb. 17, 1931 Washington DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Maryland St. Mary's Director Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20653 22266 Scott Circle United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1X Yes 2 If Yes, Give 2 No 1 ☐ Yes 2√√2 No Specify. Year or Dates Specify: White 3 Widowed 4 □ Divorced natural". the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Noncommishioned Officer Department of Defense permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen Newman Cecile Guillaume 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 348 David Hall Road Dover, Delaware 19904 Mark Newman /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Brinsfield-Echols Cre 09/06/2007 | Charlotte Hall, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home PA. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE **Physician** /Medical Due to (or as a consequence of): Examiner CHAUNIC OBSTRUCTIVE PULINGNAKY YEMRY Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed the burial-transit Due to (or as a consequence of) Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) led by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by METASTATIC CANLOR The law requires 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page certificate 1□ Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner' Other: 1 Yes 2 No A MAURICE STEPHE 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending Injury M 1 ☐ Yes 2 ☐ No investigation death after death 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 9-4-07 D56096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR RAJBINDER GILL SHAH ASSOC HOLLYWOOD MD **SEP** 0°6", 2007^{ar)} State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 02,2007 **Physician POWERS** 1139 MARY McLANE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ALLEGANY CUMBERLAND WMHS MEMORIAL CAMPUS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10-29-1926 9. Birthplace (State or Foreign Country)
MARYLAND Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔽 F 80 Yrs. Director 236-36-1402 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-1 show ary or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 1 Yes 2 No MD ALLEGANY Directo FROSTBURG 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 38 LINDEN STREET 21532 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) EDUCATION TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM OLIVER McLANE MARY BAKER McLANE ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BETH ANN LARUE DAUGHTER FEDERAL STREET FROSTBURG, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. MICHAEL CEM. 9-5-2007 FROSTBURG, MD 21532 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN ST. Sowet MOOS47 SOWERS Man FUNERAL HOME, FROSTBURG te MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** CATHS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate tause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Lest Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has the lirector, page 2 s autopsy performed? 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation after death.

I Director: A in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

SHIV KHANNA MD PA

625 KENT AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D54004

CUMBERLAND,

SEPTEMBER 3

MD 21502

, 2007

07-06742 Erica Perry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 29298

		1- For State Registrar	Cert	ificate of	Death		Red	g. No.	
Physicia		Decedent's Name (First, Middle,L	ast)				2. Date of Death		3. Time of Death
ledical Exami		Erika Denise Perry					Month August 30,	Day Year 2007	1826 hrs
		4a. Facility Name (if not institution,		4	b. City, Town, or L	ocation of Death		4c. County of Dea	th
		Mt. Zora Road	y		Conowingo	1		Cecil	
e		Social Security Number 6.	Sex 7. Age (In yrs. las	t hirthday)	If Under 1 Year	If Under 24Hrs	8 Date of Birth	(MM/DD/YYYY) 9. B	irthplace (State or
Funeral Director		5. Social Security Number	7. Age (III yis. las	st birtilday)	Months Days	Hours Min		Fore	ign
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Aaryland 28a-f show	퓽	10e. Street and Number			10f. Zip Code		. 10	g. Citizen of What Co	
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5-0036 led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified at once		117 Cooper Street	12. Was Decedent Ever in U.S	142 Wee	2191		pecify Yes or No-	USA	erican Indian, Black,
th w	Funeral	1 XX Never Married 2 Marr	Anned Forces		s, specify Cuban,			White, etc.	incan indian, black,
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iner,	3		ced If Yes, Give Year or Dates:		Yes 2000 No				White
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orthir ene.	Ē	11		Studen		A* *		Secondary E	ducation
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, La	ast)		1	8. Mother's Nam	e (First, Middle, M	aiden Surname)	
21215-003 uld be filed within Montal Hygiene. marked other th	Be	Kenneth A. Perry				Yvonne	Gibscn		
MD 212 2 should be h and Menta 27 is market imatic even	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	Address (Street	and Number or	Rural Route Numl	ber, City or Town, Sta	te, Zip.Code)
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	Funeral Director			1X M 2□F	95	Yrs.	Months		Hours	Min.	8. Date of Bir	912"	NOI	rthplace (State Country) Cth Car	olina
			Usual Residence of Decedent												
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36	a within 72 hours after death with the Maryland Jiene. r than "natural", or iteme 23a or 28a-1 ehow The Madical Examinar must be rodified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2€ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force 1204 es 2 [If Yes, Give Year or Date	s?		was Deced f Yes, spec 1 ☐ Yes :	ify Cuba	spanic Origin, Mexican Specify:	gin? (Spi , Puerto	ecify Yes or No Rican, etc.)		Black, Wh		
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Baltimore,	_ 든 본 글		4 ☐ Donation 5 ☒ Other (Special Signature of Funeral Service Lice		ım Ha	rford 1	Mem.	Gdns		9/7/		herd	een, M	arylan	d
Ba	permi Depa impo any ir		Kusten	nuxUn	gle		AD	erae	en, M	aryl	uneral and 21	001 - 1	P.A.		
4.	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	one cause on each	cut as a conseq	e Ce						rest,		Approxim Interval B Onset and	etween
O. Box 68760, ^C	that the death certificate be executed ed by the ettending physician and detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a d. 23c. If yes, outcom 1	ne of pregna 2	ancy	Ectopic pro					23	3d. Date of de Month	olivery Day	Year
P.O.	law requires that the es been signed by th 2 should be detache		Part II. Other significant conditions	contributing to death	hut not res	ulting in the ur	derlying ca	THEO ONE	n in Part I		23a Did to	phacco us	o contributo t	o the cause of	donth?
ds,	signed d be del	d by					4	3030 givo			1 🗆 1			robably 4	
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ā	in: Ti ificete or, pa		25. Was case referred to medical	Poly	anth	as his					1 ☐ Yes	2 No	1 ☐ Ye	s 2 No	
5	Physicien: r this certific ral director,	To Be	examiner? 1 ☐ Yes 2 2 No	Hospital:	tient 2	ER/Outpatien	t 3□ DO	Othe	r	of Death	Check only o		□Other (Spe		
Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 Hours eiter death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of In (Month, E		28b. Time of Injury		Bc. Injury Work		1	28d. Describe f			эспу)	
Divis	s efter de s efter de ni Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of I	njury - At h etc. <i>(Specif</i>	ome, farm, stre	eet, factory	, office		1	281. Location (5 City or Tox		Number or R	ural Route Nu	mber,
	To the Hospitel	edicai	one)	nysician: To the bes miner: On the basis and manner:	of examina stated.	ition and/or inv	estigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) a date and p	nd manner a place, and du	s stated. e to the cause	(s)
	To the within To the comp	M	29b. Signature and title of certifier	NIRZA A	BA	16: M	29c.	License						th, Day, Year)	
			15219					D	43	115		9.	-4-	0)	
	44		30. Name and address of person who		death (Item	n 23a) (Type,	Print)	Gr	ace		n)	21	870		
	Sta	te	31. Date liled (Month, Day, Year)		strar's Signa			-19		1			- 0		
	Registr		SEP 1 1 201	77	w Air	Lines	Ser. O								

504 234.14.0397

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2007 AUG. 16 2:25 P M **ELLEN WATTS PRETTYMAN** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT 405 TRIPPE AVENUE EASTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 87 219-07-9497 MARYLAND Director MAY 21, 1920 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Yes 2 □ No notified TALBOT EASTON Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 21601 USA 405 TRIPPE AVENUE Funeral ural", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ∐Yes 2**X** No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 XWidowed 4 ☐ Divorced WHITE Year or Dates: natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical BLOOD BANK OF al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 -0-OFFICE MANAGER EASTERN SHORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental if Health and Ments item 27 is marked EMMA CORKRAN JOSEPH WATTS ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 303 CHOPTANK AVENUE, EASTON, MD 21601 JAMES G. PRETTYMAN/ SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 X Burial 2 □ Cremation 3 □ Removal from State 8-22-2007 SPRING HILL CEMETERY EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MERLERS 200 S. HARRISON ST., EASTON, MD 21601 CHOK R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last to (or so consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical SB IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s autopsy perforn 1 ☐ Yes 2 ☐ No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No Hospital: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Alatural 5 Pending investigation s after dea... •al Director: Aft 1 ☐ Yes 2 ☐ No **∠** Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou

To the Fune

completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 6 CAROLYN HELMLY, **503** CYNWOOD DRIVE, EASTON, MD 21601 31. Date filed (Mor State Registrar

State of Maryland / Department of Health and Mental Hygien 2007 29301 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** August 29, 2007 6:20 Annie Virgie Phebus /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 2870 Florence Road Woodbine Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs. Director 212-74-3479 103 1904 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "naturel", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21797 2870 Florence Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If item 27 is marked other tr
eny injury or other treumatic event, ITM
QUICE. homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laura Jane Appleby Robert Wesley Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2870 Florence Road, Woodbine, Maryland Irma Duvall, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 ☐ Other (Specify) 9/1/2007 Poplar Springs Cem. Poplar Springs, MD 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on bach line. 26401 Ridge Road, Damascus, Maryland Approximate Interval Between Onset and Death Immediate Cau an Final disease or condition resulting in death) Physician dra day /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ettending physicien end for use es the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 🛛 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 🗷 No 3 Probably 4 Unknown 1 Tes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate hes funeral director, pege 2 autopsy performed? 1 ☐ Yes 24 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 🗌 Inpatient Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending 1 X Natural 1 Tyes 2 No deeth. М investigation 2 Accident efter deeth 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours e To the Funerel I completely filled To the Hospital 🌋 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medicai (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contilie 29c. License number 29d. Date signed (Month, Day, Year) August 30, 2007 D46096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hope A. McIntyre, MD, 1502 South Main Street, Mt. Airy, Maryland 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

07-06722 Amy Michelle Ross

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2007 29302

	1- For State Certi	ificate of Death	Reg. No 2, Date of Death	3. Time of Death
Physician/	Decedent's Name (First, Middle,Last)		Month Day	Year 2220 hrs
Examiner			August 29, 200	c. County of Death
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location	I or Death	Anne Arundel
	Anne Arundel Medical Center	Annapolis	Į.	
Europol	5. Social Security Number 6. Sex 7. Age (In yrs. las	of Directory)		//DD/YYYY) 9. Birthplace (State or Foreign
Funeral Director	17	Months Days Ho	DECEMBER 9	
Director	214-27-0700			
	Usual Residence of Decedent	Town or Location		10d. Inside City Limit
Maryland 28a-f show any d at once.	Toa. State			.1 Yes 2 X N
show	MARYLAND QUEEN ANNE'S STE	EVENSVILLE	10a C	itizen of What Country?
2 should be filed within 72 hours after death with the Maryland hand Mehial Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once To Re Completed by Funeral Director	10e. Street and Number	10f. Zip Code		
the Maryland a or 28a-f sh tified at once Director	929 MONROE MANOR ROAD	21666	UN	TED STATES
death with the Maryland or items 23a or 28a-f sho must be notified at once-uneral Director		S. 13. Was Decedent of Hispanic	Origin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
th w	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexi	can, Puerto Rican, etc.)	
or items 23	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Yeer	1 Yes 2 X No spec	cify:	Specify: WHITE
ted within 72 hours after Tygiene. other than "natural", the Medical Examiner Completed by	3 Wildowed 4 Divolced or Dates:	16a Decedent's Usual Occupation (G	live kind of work done 16b	. Kind of Business/Industry
uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner for Re. Completed by	15. Decedent's Education (Specify only highest grade completed)	during most of working life. DO N	IOT use retired)	The second secon
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ithin I tha	12	STUDENT	other's Name (First, Middle, Maid	en Surname)
ed within 72 hour: lygiene. other than "natu he Medical Exan	17, Father's Name (First, Middle, Last)			
be fill rked rked ent, 1	JONATHAN MICHAEL ROSS	GA	YLE BLATTENBER	City or Town State Zin Code)
ould b		19b. Mailing Address (Street and		
sho and 27 is mati	TONATHAN M. ROSS / FATHER	929 MONROE MANOE	R ROAD, STEVENS	VILLE, MARYLAND 216 oc. Location - City or Town, State
ealth em)	20a Method of Disposition 20b.	Place of Disposition (Name of cemeter crematory or other place)	y, Date 20 SEPTEMBER 5	c. Location - City or Town, State
permit. Pages 1 and 2 should-be filed within peperment of Health and Wintal Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med To Re Comments.	4 During 2 A Cremation 3 Removal from State			TEVENSVILLE, MARYLA
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permit. Departn Import	21. Signature of F eral Service censee	FELLOWS, HELL	ENBEIN AND NEW	NAM FUNERAL HOME, I
II. II. De	(ADE XELL)	I 1 A CTI AMDACK	ROAD CHESTER	MAKILAND ZIUIZ
ysician	23a. 1 ter the disease, or complications that caused the death	. Do not enter the mode of dying, such	as cardiac or respiratory arrest,	Between Onset
Medical	failure. List only one cause of the line.			Death
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ficate be ex g physician s the burial	#20I, penvic, go/			23d. Date of delivery
icate g phy the l	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pred 1 Live birth		Ectopic pregnancy	Month Day Year
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atte for u	1 Yes 2 No 9 V Unknown g Unknown			
he de	past 12 months? 1 Yes 2 No 9 V Unknown 2 Unknown Part II. Other significant conditions contributing to death but not	resulting in the underlying cause giver		acco use contribute to the cause of death
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requ been hould			autopsy perform	
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ing Physician: The law After this certificate has funeral director, page 2 s	8	26.Place of	Death (Check only one)	
ian: certif	25. Was case referred to medical			esidence 6 Other:
rysic this	O 1 Ves 2 No	28b. Time of Injury 28c. Injury a	t Work? 28d Describe ho	w injury occurred
ng Pl	27. Manner of Death 28a. Date of Injury (Month., Jay Year) 28 Aug 29, 2007		2 ✓ No Driver auto tr	uck collision
tal or Attending Physician: The law requirers as after death. "In Director: After this certificate has been silted in by the funeral director, page 2 should be	a rending			Dural Pauto Numbo
Atte	Accident Investigation 28e. Place of Injury - At	home, farm, street, factory, office build	ding, etc. 28f. Location (Str	reet and Number or Rural Route Number ate)S/B on General S Hwy.
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spits nours	29a. Certifier 1 Certifying Physician: To the best of my knowledge.		and place, and due to the cause	(s) and manner as stated.
To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as	Certifying Physician: To the best of my knowledge (Check only)	and/or investigation, in my opinion, de	eath occurred at the time, date a	nd place, and due to the cause(s)
To the To the To the Complex	and mather/stated.	29c. License r		29d. Date signed (Month, Day, Year)
FSFO	29b. Signature and little of certifier			August 30, 2007
	1 XI ACAUN IVI	O.C.M.	⊏.	August 50, 2007
,	30. Name and address of person who completed cause of death (It	em 23a)	<u> </u>	
5		er 111 Penn Street, Baltim	ore, MD 21201	
St	ate 31. Date filed (Month, Day, Year) 32. Redistrar's Sign	1. Coule		
Regist	rar AUG 3 1 2007 Meeur	I produce		
		ORIGINAL		OCME

State

e of Maryland / Department of Health and N Certificate of Death	ntal Hygiene Reg. No	2007	29303
	2. Date of Death Month Day	y Year 3 2007	3. Time of Death

Physician	
/Medical	
Examiner	

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

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4a. Facility Name (street and nu	umber)			41	b. City, 7		Location	of Death	h			ounty of Dea			
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127-30-8	3691		X M 2□F	/ Age	67	Yrs	M	Ionths	Days	Hours	Min.	JUN	nth, Day, 1	1940	NE	W Y	ORK	
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10e. Street and Nu	ımber						1	10f. Zip	Code				10	g. Citizen	of What C	ountry	?	
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17. Father's Name		e, Last)											Middle, M		rname)			
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State Registrar

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		- For State Certificate	of Death	Reg. N	lo. 200	7 293
Physician	1/ 1	Decedent's Name (First, Middle,Last)	N.	Date of Death Month Da	v Year	Time of Death 2102 hrs
al Examine		Patrick Edgar Roth		ugust 28, 20	007 4c. County of Death	21021115
	4	4a. Facility Name (if not institution, give street and number) 11000 Bethesda Church Road	4b. City, Town, or Location of Death Damascus		Montgomery	
	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth (M	IM/DD/YYYY) 9. Birthp	lace (State or Foreign
Funeral Director	П		Months Days Hours Min.	•	Count 1953 Sout	ry)
	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lot		TIE		Od. Inside City Limits
w any	ı	, , , , , , , , , , , , , , , , , , , ,	cation			Yes 2 X No
Pages and 2 should be lited within /2 hours after death with the Maryland tent of Health and Mantal Hygiene. If Iffine 27 is marked other than "natural", or items 23a or 28a-f show in other traumatic event, the Medical Examiner must be notified at once. To Bo Completed by Euroral Director	اع	Maryland Montgomery Damascus 10e. Street and Number	10f. Zip Code	40= (Citizen of What Country	
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	4	23a. P. III Enter the disease, or complications the caused the death. Do not enter	26401 Ridge Road, Da	amascus,	Maryland	208/2
				eniratory arrest	chock or heart	Approximate Interva
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State of Maryland / Department of Health and Mental Hygiene	

		,	For State	State of	of Marylan		artment of H rtificate of		d Men			2007	00005
			Registrar 1. Decedent's Name (First, Middle	e, Last)			timouto or	Douth	2. [Date of Death	g. No.	2001	3. Time of Deam
П	Physici			WARD	RUSSELI	Γ.				Month GUST 2	Day 28	Year 2007	12:21 P M
· ·	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	or Location of D		G051 -		County of Death	
			FREDERICK MEM	ORIAL HOS	PITAL		FREDERI				FR	EDERICK	
h	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Vlin. (Date of Birth Month, Day,		Cou	
	Director		214-48-9493 Usual Residence of Decedent		59	115.			Se	pt 20,	19	47 Mary	land
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
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	th the or 28s	Director	10e. Street and Number	2 2 0 10	1110111	OVIA	10f. Zip Code			10	g. Citiz	en of What Cou	ntry?
	23a cust b		4205 Lynn Burke	Road			21770			τ	JSA		
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	Armed F		.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? an, Mexican, P	? (Specify Puerto Rica	Yes or No- n, etc.)	1	 Race - Ameri Black, White, 	
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Maryland	12 sh hand 7 is m traum		19a. Informant's Name/Relations				ng Address (Street			Ť	-		,
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	- 1		23a. Part1. En er the disease, or shork, or leart failure. List	complications that	caused the deat	h. Do not ent	er the mode of dy	ng, such as car	rdiac or res	spiratory arre	est,		Approximate Interval Between
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A e	/Medical		resulting in death)		(or as a conseq		-11-02-00						
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	Hos 24 ho Fun etely	Medical		Examiner: On the									
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certific		/		29c. Licen	se number		29	9d. Date	signed (Month	, Day, Year)
)	- > - 0		Lown	el 12	va-e	· · · · ·	O DO	0061884			8/	29/07	
•	ID		30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type,	Print)				•		
	10		Leonard Kane,				son Ct. S	Suite B	Fre	derick	, M	aryland	
	Sta		31. Date filed (Month, Day, Year,	0 2007	Registrar's Signa	ature	book						
	Regist	खा	ผบน อ	A 5001		-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 29306 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year James 0scar Redding 10:56 A^M 29, 2007 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13 Diller Court Boyds Montgomery 6. Sex 1 AM 2 ☐ F 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Director 239-54-3976 70 Apr. 19, 1937 North Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "natural", or iteme 23s or 28s-f show treumstic event, the Madical Examiners, ust be putified at 10d. Inside City Limits 1 Yes 2 No Directo Maryland Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Diller Court death y Funerai 20841 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married XYes 2□No 1967-Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1969 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient important: if item 27 is marked other the any injury or other treumatic event, Ins. Once. 5+ Psychiatrist Hosptial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Penn Wood Redding Kate Elizabeth Alcorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcella Joyce Redding, wife 13 Diller Court, Boyds, Maryland 20841 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 8/31/2007 Alexandria, Virginia 21. Signature Funeral Service Licenses 22. Name and Address of Facility Molesworth-Williams Funeral Home yoush. 26401 Ridge Road, Damascus, Maryland 23a Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ASCVD /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) ned by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one ဂ္ Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA SIL 27. Manner of Death 2Ba. Date of Injury (Month, Day Year) of or Attending Parties death. 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation M 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours at To the Funerel D completely filled in cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

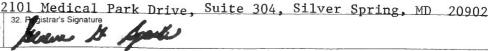
State Registrar 31. Date filed (Month, Day, Year) AUG 3 0 2007

(46

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Ira N. Brecher, MD,



-MODREE

29c. License number

D00428

29d. Date signed (Month, Day, Year)

August 30, 2007

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, Sta

		For State Registrar	State of Maryland		ertificate of L		lental Hy	giene Reg. No	2007	29307
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xamin		4a. Facility Name (If not institution, give s. 1500 East Randolp) 5. Social Security Number 6. Sex	h Road	st birthday	Silver	If Under 24 Hrs.	8. Date of Bir	th I	County of Death Montgom 9. Birth	ery place (State or Foreign
ineral rector	g)	215-35-4108 Usual Residence of Decedent	M 2□F 55	Yrs.	Months Days	Hours Min.	(Month, Da Dec. 31	y, Year)	Cou	yana
8a-f show otified at	Director	10a. State 10b. County Maryland Montgome		Town or l	r Spring					10d. Inside City Limits 1 ☐ Yes 毅致No
s 23a or 2 nust be no		10e. Street and Number 1500 East Rando	_=	Lan	10f. Zip Code 20904	. 0 0		τ	en of What Cou JSA 4. Race - Amer	
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	. 13	3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Sp in, Mexican, Puerto Specify:	ecity Yes of No Rican, etc.)		Black, White	, etc.
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ked other t c event, th	To Be Co	17. Father's Name (First, Middle, Last) Clement Ignatius	Rodrigues	Asse	mbly Worke	18. Mother's Nam		Maiden S	,	rkshop
27 Is mari	Ĕ	19a. Informant's Name/Relationship (Type Marquerite Monica	pe. Print)		iling Address (Street a	and Number or Rui	ral Route Numb	er, City or	Town, State, Z.	,
ant: If item ury or othe		20a. Method of Disposition ★★Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20b. Pla emoval from State	ace of Disp metery, cr	position (Name of ematory or other plac Heaven Cen	e) Aug	Date 29,	20c. Loc	ation - City or 1	
Import any inj once.		21. Signature of Funeral Service License				sity Blv	d, W.,	Silve	me Inc. er Spri	ng, MD 2090]
sician edical		23a. Fal 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Congestive F	leart		g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death 1-2 Years
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physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Down Syndrom Due to (or as a conseque						F:	rom Birth
been signed by the attending pl should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnan 1 □ Live birth 2 □ Fetal of the second o	death 3	B □Ectopic pregnancy			23	3d. Date of deli Month	very Day Year
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To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 E	R/Outpati 28b. Time Injury	of 28c. Injur	y at	ome 5 XResi 28d. Describe			ify)
al Director ed in by the	Certification:	3☐ Suicide 6☐ Could not be 4☐ Homicide determined	28e. Place of injury - At hon building, etc. (Specify)	me, farm, s	street, factory, office		28f. Location (City or To		Number or Ru	ral Route Number,
the Funer	Medical ((Check only 2 Medical Examir	sician: To the best of my knowner: On the basis of examinatiand manner stated.	/ledge, de on and/or	investigation, in my o	pinion, death occu	, and due to the rred at the time,	date and	place, and due	to the cause(s)
Com	Δ	29b. Signature and title of certifier	and		29c. License	39947			signed (Month	
		30. Name and address of person who con Mona Ellis, M.D	344 Universit	y B1	vd, West,	#213, Si	lver Sp	ring,	MD 20	901
Sta Registr		31. Date filed (Month, Day, Year) AUG 2 8 200	32 legistrar's Signatu	k d	ante					

	Physician
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

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Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	al Dir		6 Dove	Street			101. Zip CC		904		10g. Ci	U.S.		
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification	4 ☐ Homicide	determine	[™] building,	etc. (Specif	y)	- 7			City or To				
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4		30. Name and add	ress of person wh	o completed cause o	of death (Iten	n 23a) (Type	, Print)			0/ 1 1		/		

State Registrar HRTHUR

31. Date filed (Month, Day, Year)

AUG 2 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 7 FH TCHD 09/07/07 State of long the state of long the long that the lon State of Maryland / Department of Health and Mental Hygien 1 Certificate of Death 2. Date of Death 3. Time of Death **Physician** Elleanor 19 2007 Jeffers Simonoff August 08:36 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 110 Talbot Street Talbot Easton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1□M 2√X Months Days Hours Min. Maryland Yrs. **Director** 8027 217 54 61 Oct 30 1945 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits in than "natural", or Itams 23e or 28e-f show the Madical Examiner must be notified at 1 XYes 2 ☐ No Director Easton Talbot Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Talbot St 21601 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Whi Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12 h and Mental Hygie 7 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Jeffers Hester Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health : Edward Simonoff (spouce) 110 Talbot Street Easton Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
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Important: If ites
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 8/20/2007 Salisbury Crem Salisbury, Md. Dashiell F.S. F.322 East Av Easton, Maryland 21601 21. Signature of Funeral Service Licensee F.322 East Ave. MODIBL STUR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as or injury Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) hrs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Backbons Pt NI. Oxpano mo 21654 Ok Kaprowak NA 4410 lande 32 Registrar's Signature 31. Date filed (Month, Day, Year) AUG 2 1 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 1:50AM M VIRGINIA M. SCANLAND AUGUST 18 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner RUXTON HEALTH OF DENTON DENTON CAROLINE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, NOV • 7) Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1912 1 □ M 2 □XF MARYLAND 94 Director 212-26-3882 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1√ Yes 2 No 28a-f sh notified Director CAROLINE DENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 21629 420 COLONIAL DRIVE USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or items 23s 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Completed by Specify. 3 XWidowed 4 ☐ Divorced WHITE item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 TEACHER **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ JOHN T. MEREDITH MINA (UNKNOWN) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 TRAFALGAR ROAD, DOYLESTOWN, PA 18901 ROBERT B. SCANLAND, JR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 8/21/2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Joseph 20 CF.S.R 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** to disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** Demonto Sequentially list conditions, if the Linds in the line cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse uence of Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i 9 Unknown 9 Unknown signed by be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 MD D0061688 2007 Oha 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIDONARO DRIVE, LINESTER DESA 2108

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** John David Staling 2007 September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours N 2 □ 79 577-34-4549 Director Washington DC 12/13/1927 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Director Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21713 8507 Mapleville Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. δ 3 V Widowed 4 □ Divorced white Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Electronic Tech 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Brown ပ George F. Staling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6166 King Rd. Boonsboro, MD 21713 Catherine S. Scuffins/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Cremetory 9/8/2007 22. Name and Address of Facility Resthaven Funeral Chapel 21. Signature of Funeral Service Licens 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Chronic OU SHY4CT /Medical Due to or as a consequence of): Examiner Yostate Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown is certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No Attending Physician; 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗗 ÎNo 1 Inpatient 2 KER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 🗚 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the Director 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or A 24 hours after of 4 Homicide To the Hospital of within 24 hours at To the Funeral L 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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Opal Court

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

1126

State of Maryland / Department of Health and Mental Hygiene 107 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year William White Vance Jr. 09 02 07 2348 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS- Braddock CAmpus Cumberland **Allegany** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month Day, NOV 23, 9. Birthplace (State or Foreign Funeral **¼**□ M 2□ F Months 220-38-0002 65 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b, County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD Allegany Cumberland Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 221 Grand Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 ğ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) dry wall mechanic National Applicators Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, ti once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William V. White, Sr. Maxine Simpson Lechliter ပ 19a. Informant's Name/Relationship (Type. Print)

Joyce White 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) 221 Grand Avenue Cumberland MD 21502 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/6/2007 Cresaptown MD 4 Donation 5 Dother (Specify) 21. Signatur of Foneral Service License 22. NameScandemsPurnellal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** seppes Some admi /Medical Due to (or as a consequence of): ce Admi **Examiner** cardo valula accelled Sequentially list conditions, from Lind Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Sur admi Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2K No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) faul share mo DO066101 9/4/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABOUL HAVAN CHIEFMA: 00cumberland Seton 31. Date filed (Month, Day, Year) 2. Registrar's Signature Registrar

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Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036 within 24 hours after dead To the Funeral Director: filled Hospital 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 J 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Ave, Chestertown MD 216 20 10 415 K. WUN. 32. Registar's Signature 31. Date filed (Month, Day, Year) State AUG 3 1 2007 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 08/23/2007 Ah Mee Ching Weber 0958 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours 1 □ M 2000 0871871922 Hawali 575-14-9504 Director Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Anne Arundel Crofton 1 □Yes 2/XNo 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n 1734 Straton Rd. 21114 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 □ Yes 2 ☑ No f Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Chinese <u>Ş</u> 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Contract Admin NSA Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fill and Mental H Kwong Sung Ching Tom Shee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Mann Daughter 10110 Baileysburg Lane Nokesville, VA 20181 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/5/2007 Arlington National Arlington, VA 21. Signature of Funeral Service 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Fibrillation Physician recent disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 KNo 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been sig page 2 should b 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

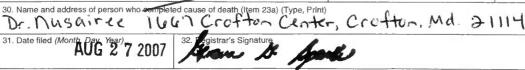
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ie Hospital or Attendi 24 hours after death. e Funeral Director; A 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 2

31. Date filed (Month Pay Year) 7 2007 Registrar

29b. Signature and title of certifier



and manner stated.

29c. License number

D0040519

29d. Date signed (Month, Day, Year)

8-24-07

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

AUG 2 7 2007

DHMH 17 Rev 1/2001

Registrar

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JANET B. WILLIAMSON 4a. Facility Name (If not institution, give street and number) TALBOT HOSPICE HOUSE 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 091-20-5289 80 Director Usual Residence of Decedent show 10a. State ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Director TALBOT MD JANET WILLIAMSON 10e. Street and Number 700 PORT ST., UNIT 110 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 2 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wn Department of Health and Mental Hygien. Important: If item 27 is marked other tha any lnjury or other traumatic mental once. 12 17. Father's Name (First, Middle, Last) Be HARRY O. BAGLEY 19a. Informant's Name/Relationship (Type. Print) JILL WILLIAMSON/DAUGHTER Baltimore, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses m. Ostrowski Lough Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner here icteratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2 12 No 4□Pregnant at time of death detached 9 Unknown 2 Completed page 2 s l or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 1 ☐ Yes 21 No Certification: To 1 | Inpatient this 27. Manner of Death 28a. Date of Injury 28b. Time of After (Month, Day Year) 1. Natural 5 Pending death. investigation 2 Accident after death filled in by the Could not be determined 3 ☐ Suicide 4 Homicide within 24 hours a To the Funeral C Hospital 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. SANCHEZ, M.D. 508 IDLEWILD AVE., EASTON, MD 21601 31. Date filed (Month, Day, Year) gistrar's Signature State AUG 27 Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}22 AUGUST 2007 6:25AM M 4b. City, Town, or Location of Death 4c. County of Death TALBOT EASTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | DEC 28, 9. Birthplace (State or Foreign NEW YORK Months 1926 10c. City, Town or Location 10d. Inside City Limits 1 ☑Yes 2 ☐ No EASTON 10f. Zip Code 10g. Citizen of What Country? 21601 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 XNo Specify. Specify: WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) LORENA SLOAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 328 CLIFTON AVE., ARNOLD, MARYLAND 21012 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State CHESAPEAKE CREMATION CTR 8/23/2007 STEVENSVILLE, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death cerebrovareula 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform 1□ Yes 2□No 26. Place of Death (Check only one) Other: ${}_4\Box$ Nursing Home ${}_5\Box$ Residence 6 \Box Other (Specify) HOSPICE 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 12575 رتي

State of Maryland / Department of Health and Mental Hygiene 29322 Reg. No. 2 1 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Elizabeth Helen Waymoth August 25, 2007 12:00p M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11509 Highview Avenue Wheaton Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 K Months Days Hours Min. Yrs Director 308-18-8153 88 June 5, Indiana 1919 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be n 11509 Highview Avenue 20902 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after 1 ☐ Yes 2√3 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No ģ Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Secretary Private permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Mooney Irene Overby 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Waymoth/Husband 11509 Highview Avenue, Wheaton, MD 20902 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State August 28 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francisdogs of Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Microvascular Disease Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O, Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed' 1∏ Yes 2 X No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Pruneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only To the I within 2 29b. Signature And title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09577 August 27, 2007 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Pollen, M.D. 10400 Connecticut Avenue, Kensington, MD 20895 AUG 28 31. Date filed (Month, egistrar's Signature State 2007 Registrar

			For State	State	of Mary		artment of I		Mental Hy	giene Reg. No. 200	7 29323
			Registrar 1. Decedent's Name (First, Midd)	lle, Last)			Timodio oi	Douth	2. Date of De	ath	3. Time of Death
	Physici /Medic		Kathleen	S.	Wesc	hler			Month Augus	Day Yea	6.55 a M
,	Examin	_	4a. Facility Name (If not institution				4b. City, Town, o	or Location of Dea		4c. County of De	
			4300 Brookfie				Kej	nsington		Mon	tgomery
	Funeral		5. Social Security Number 577–28–5845	6. Sex 1 ☐ M 2X		yrs. last birthday) $\Delta \qquad \qquad \text{Yrs.}$	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir (Month, Da	th ly, Year) 2 4, 1923	irthplace (State or Foreign
	Director		Usual Residence of Decedent		0	4			March	24, 1923	Ohio
	yland iow at		10a. State 10b. County	у	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fsh ified	ctor	Maryland	Montgo	mer.		Kensing	ton			1 □ Yes 2X No
	or 28	Director	10e. Street and Number	J	_		10f. Zip Code	COH		10g. Citizen of What (Country?
	death with the Maryland ms 23a or 28a-f show r must be notified at		4300 Brookfi					20895		USA	
	er de items	Funeral	11. Marital Status	Arme	Decedent Ever d Forces? es 2 ∑ No	in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S oan, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Hace - Ar Black, Wi	nerican Indian, nite, etc.
5	rs aft l'', or xami	by F	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	If Yes	, Give or Dates:		1 ☐ Yes 2 🛣 No	Specify:		SpecWhit	te
2-0036	2 hou	ted	15. Decede (Specify only highe	nt's Education	in all	16a. Dece	dent's Usual Occu	pation	nel-in-	16b. Kind of Busines	s/Industry
7	be filed within 72 hours after death with the Marylar tha Hyglene. do other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	- i	ge (1-4or 5+)	`life.	DO NOT use retire	ed)	orking .		
7	e filed wi al Hygien other th vent, the	Co	12				Homemake		/FT 4 847 4 11	Own Ho	ome
and	htal H	Be	17. Father's Name (First, Middle Charles B. Sh						lme (<i>First, Middle</i> Lotte Ku:	, Maiden Surname)	
5	ges 1 and 2 should be f t of Health and Mental I If item 27 Is marked of or other traumatic eve	유	19a, Informant's Name/Relation			19b. Maiti	na Address (Stree			er, City or Town, State	Zin Code)
<u>8</u>	nd 2 s Ith an 27 Is		Ralph A. Wesc				,			mac, MD 208	,
ē,	is 1 and 2 of Health item 27 I		20a. Method of Disposition	,	2	Ob. Place of Dispo			Date	20c. Location - City	
Saltimor	permit. Pages Department of I Important: If ite any injury or ot		1 Burial 2 Cremation 4 Donation 5 Other (rom State		Heaven (Aug. 29, 2007	Silver Spi	ring, Maryland
<u>=</u>	rmit. partn porta y inju		21. Sign were of F) neral Service	e Licensee			2. Name and Addr				ā ā
מ	9 3 E 8 5		* Kirkerd	Z.A.W	b	5	00 Univer	sity Blv	d., W.,	l Home Inc. Silver Spi	ing, MD 2090
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	or complications that only one cause	nat caused the on each line.	death. Do not en	ter the mode of dy	ing, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in dodary	Due	e to (or as a co	nsequence of):					
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	cate be executed oblysician and the burial-transit	Examine	Cause (Disease or injury that initiated events	S .							
Ď	exec an an rial-tr		resulting in death) Last	Due	e to (or as a co	nsequence of):					
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Õ	death certificate be executed e attending physician and of for use as the burial-transit	Med	IF FEMALE:								
gox	w requires that the death certific been signed by the attending p should be detached for use as	hysician/Me	23b. Was decedent pregnant in the past 12 months?	1 🗆 L	, outcome pf p ive birth 2 □ regnant at time	Fetal death 3	⊒Ectopic pregnanc	_Б у		23d. Date of o	lelivery Day Year
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cord	law rec as bee 2 shou	Completed							24a. Was	an 24b. Were	autopsy findings available
Ž	0 <u>c</u> 0	mo						1991	auto perfo 1∐ Yes	psy prior to prmed? death 2 No 1 TV	o completion of cause of ? es 2 □ No
VITal	sician: Th certificate rector, pag	Be C	25. Was case referred to medic examiner?	al				26. Place of De	eath (Check only o		
	Physician: this certific ral director,	To E	1 ☐ Yes 2 No			2 ☐ ER/Outpatie	III JUDON		Home 5₹Resi	dence 6 ☐Other (S)	pecify)
0 00	ding P h. After t funera		27. Manner of Death 1 Natural 5 Pendi	ing (ate of Injury Month, Day Ye	ear) 28b. Time o	Wo		28d. Describe	how injury occurred	
NISIO	ttend leath. tor: /	cati	3 Suicide 6 Could		lage of injune	At home farm st	M 1 creet, factory, office]Yes 2 □No	20f Location (Street and Number or	Pural Pouto Number
\leq	or A after of Direct I in by	Certification:	4 ☐ Homicide deter	mined 20e. F	uilding, etc. (S	pecify)	reet, factory, office		City or To	wn, State)	nurar noute rumber,
	the Hospital or Attending hin 24 hours after death. the Funeral Director: After Tipletely filled in by the funer									cause(s) and manner	
	n 24 h	edical	(Check only 2 ☐ Medic a one)		he basis of exa manner stated.	amination and/or li	nvestigation, in my	opinion, death occ	curred at the time	, date and place, and o	lue to the cause(s)
	withir To th	Me	29b. Signature and title of certifi	ier	. +	•		se number	4.0	29d. Date signed (Mo	nth, Day, Year)
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		10	31. Date filed (Month, Day, Year	Wiscor	Registrar's	Signature C	+ 302	verue	ua, m	10 Day 01	1
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State of Maryland / Department of Health and Mental Hygiene A. C.

Physici /Medic		1. Decedent's Name (First, Mi Karen E. Ale	,				2. Date of De Month Augus	Day	007	3. Time of Death 4:15 PM M
Examin		4a. Facility Name (If not institu)		n, or Location of Dea	th		ty of Death	
		3369 Justice 5. Social Security Number		and the section to the terms	Walc			Char		
Funeral Director		036-32-6797 Usual Residence of Decedent	1 M 2 M F	ge (In yrs. last birthday,	Months Day		8. Date of Bir (Month, Da June 2	I, 1947	9. Birthi Coul Rho	place (State or Foreign ntry) de Island
e how		10a. State 10b. Cou	nty	10c. City, Town or L	ocation					10d. Inside City Limits
- 9	cto	MD Cha	arles	Waldo	rf					1 ☐ Yes 2 No
or 28	SIre.	10e. Street and Number			10f. Zip Code			10g. Citizen o		ntry?
238	La I	3369 Justice	Court			20602		U	SA	
ene. than "netural", or iteme 23a or 28a-f ehow ha Medical Examiner must be molified at	by Funeral Director	11. Marital Status 1X Never Married 2 □ M 3 □ Widowed 4 □ Divord	If Yes Give	? INo	Was Decedent of If Yes, specify C	of Hispanic Origin? (: uban, Mexican, Pue No Specify:	Specify Yes or No to Rican, etc.)		ice - Americ ack, White, ify: whi	etc.
netur	Completed	15. Deced	lent's Education hest grade completed)	16a. Dece	dent's Usual Occ	cupation ne during most of wo	orkina	16b. Kind of	Business/In	dustry
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Ith ar 27 ts r trau		Sgt Minor/Cha			ng radioss (one	or and reamber or re	5141710515745775	or, Only or row	i, Diaro, Zip	, 60000)
ment of Heatt ant: if item 2 ury or other		20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other	n 3 □Removal from State (Specify)	20b. Place of Disposemetery, cre	osition (Name of matory or other p	olace)	Date	20c. Location	- City or To	own, State
Department Important: 1 eny injury o		21. Signature of Funeral Servi	ce U censee Wade, Dir		2. Name and Add tate Ana	tress of Facility tomy Boar	d 655 W.	Baltin	ore S	street
		23a. Part1. Enter the disease	or complications that cause ist only one cause on each	d the death. Do not en	ter the mode of d	, MD 212 lying, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
g physicien and as the burial-transit	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or a	s a consequence of): s a consequence of): s a consequence of):	MER					
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ed by the attendir detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3	□Ectopic pregnar □ Other (specify)	псу		1	ate of delive	ery Day Year
igned b	by Pt	Part II. Other significant cond			inderlying cause	given in Part I.	23e. Did t	obacco use co	ntribute to t	he cause of death?
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ate has be pege 2 sh	Completed						24a. Was autoj perio 1 Pes	psy ormed?	Were auto prior to co death? 1 \(\text{Yes} \)	opsy findings available impletion of cause of
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this or	ပ္	1 ☐ Yes 2 ☐XXNo	Hospital: 1 Inpat	ent 2 ER/Outpatie	11 3 00A		lome 5 X Resi	dence 6 □O	her (Specif	5/)
After	atlon:	27. Manner of Death 1 Natural 5 Pen 2 Accident inve	28a. Date of Inj (Month, Date stigation	ury 28b. Time o ay Year) Injury	W	jury at /ork? ∐Yes 2∐No	28d. Describe	how injury occu	rred	
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within 24 hours efter death To the Funaref Director: completely filled in by the	edical (29a Certifier 1 Certific (Check only one) 2 Medic	al Examiner: On the basis and manner s	of examination and/or in	h occurred at the vestigation, in my	time, data and plan y opinion, death occ	e, and due to the urred at the time,	date and place	anner to a , and due to	tated. the cause(s)
- 출 불	ž	29b. Signature and title of certi	for) Brin		1	nse number		29d. Date sign	ed (Month,	Day, Year)
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24a, 25, 26, 34a, 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 192 ANDEMON FOOL sente 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltmore 8 Maryland Medical Centu If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**万**M 2□F Months 216-62-7581 Usual Residence of Decedent Director 10c. City, Town or Location 10b. County 10d. Inside City Limits MARYLAND 10e. Street and Number 1 X Yes 2 □ No Funeral Director Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TANITORIAL SERVICE 9THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is marfany injury or other traumationes. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET ANDERSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MARYLAND 21. Signatu re of Funeral Service Licensee 22. Name and Address p RAWN JK. FUNERAL HOME BALTO, HD212 FULTON AVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a rest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical **Examiner** deno carcinome Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

attending physician and

cate has been signed by page 2 should be detact

After this certificate

burial-tra

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner must be notified at

items 23a or

"natural", or

is marked other than

injury or other traumatic event, the Medical

within 24 hours a

To the Hospital or Attending Physician:

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

5+ GITTERNE

Baltimore

29c. License number

ddress of person who completed cause of death (Item 23a) (Type, Print)

21201

Hassen-Ahmed, Abdo-Abdollah Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 29326 UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day August 19, 2007 0055 hrs Medical Examiner Hassen Ahmed Abdo-Abdollah 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cecil Big Elk Mall Elkton 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or unk **Funeral** Months Foreign Country) Hours Director 1 XM 2 F Sept 9, 1967 39 Yrs Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a, State 10h County 1 X Yes 2 No MD Baltimore 23a or 28a-f shov notified at once. with the Maryland Director unk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4613 Eastern Avenue 21224 12. Was Decedent Ever in U.S. Funeral unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, other than "natural", or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes 1 X Yes 2 No specify: mexican white after If Yes, Give Year 3 Widowed 4 Divorced Specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done ${
m unk}$ 16b. Kind of Business/Industry unk during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 h ment of Health and Mental Hygiene. tan: If item 27 is marked other than "n or other traumatic event, the Medienal F. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 unk lunk unk unk 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) æ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 21. Signature of Rollard Service Licensee , Director 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hanging Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X AMENDED 21 per dwr 9871 9-13-07 vt UNPENDED signed by the attending physician be detached for use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available

The law requires that the death certificate be executed Records, P.O. Division of Vital

Completed page 2 should 24a. Was an certificate has been autopsy performed? 26.Place of Death (Check only one) director 25. Was case referred to medical Be Other₄ examiner? Hospital: Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene this 1 🗸 Yes ۵ funeral After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Aug 18, 2007 1 Subject hanged self 0000 hrs Natural Yes 2 V No hours after death.

uneral Director: Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be within 24 hours at To the Funeral D determined (Specify) Mall Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier O.C.M.E August 19, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State) Big Elk Mall, Elkton, Md

prior to completion of cause of

death? 1 🗸 Yes

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

32 Registrar's Signature Elli Gere

Registrar

			For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	rtificate of		лептат нуд	eg. No. 2007	29327
	Physici	an '	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		Helen C.	Anthony	3			September		
)	Examin	er	4a. Facility Name (If not institution, give:				r Location of Death ใかって		4c. County of Deat	th
H	Funeral		5. Social Security Number 6. Set		(In yrs. last birthday)	If Under 1 Year		8. Date of Birth	9. Birt	A hplace (State or Foreign
₩. 	Director		216-20-9213]м 2🕱 F	82 Yrs.	Months Days	Hours Min.	(Month, Day, 4/1/25	Year) Co	yland
	yland yland at		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar Ba-f sl tiffied	Director	Md Anne Aru	ndel	Bal	timore				1 ☐ Yes 2 Mano
	or 28	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	s 23a	eral	2 Nann Avenue	10 W D		2122		1. 1/ 1/	USA	alaan Indian
9	be filed within 72 hours after death with the Maryland rital Hygiene. so other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	/ Funeral	1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give	io	was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	hours tural", al Exa	ed by	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Edu	Year or Dates:		dent's Usual Occup		- 1	W	hite
5	in 72 n "na"	Completed	(Specify only highest grad	e completed)	(Give	kind of work done DO NOT use retired	durina most of work	king	16b. Kind of Business/	industry
212	d with giene er thau	mo	Elementary/Secondary (0-12)	College (1-4or 5-	·	anitor			School	System
p	0 = 0 0	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, I	Maiden Surname)	
<u>ya</u>	should be filed and Mental Hygi s marked other numatic event, II	2	John Anthony					Gertrude		
Ja	12 sh h and is m raum		19a. Informant's Name/Relationship (Ty			•			r, City or Town, State, 2	
	1 and Healt em 2: ther		Mrs. Donna D'Aless 20a. Method of Disposition	sio / Daug					naryland 21 20c. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispo				•	
#	nit. F artme ortan injur		21. Signature of Funeral Service Lice	ee O	Cedar Hil				Brooklyn Pa :k Funeral	rk, MD Home
ä	permi Depar Impor any ir		Lugen \	Cast					e, Marylan	
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	cations that caused ne cause on each lin	the death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Small	1 1					Onset and Death
1	/Medical Examiner		resulting in death)		consequence of):	00 11=				
B	£	<u></u>	Sequentially list conditions,		ridium di	tticile 1	Colifis			
Ţ	uted ansit	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	exect an and rial-tra	Exa	resulting in death) Last	Due to (or as a	consequence of):					
68760,	tificate be executed g physician and as the burial-transit	edical		l						
			IF FEMALE:							
.O. Box	The law requires that the death certiate has been signed by the attending age 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome p 1□Live birth 4□Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	/		23d. Date of del Month	ivery Day Year
o.	res that the de signed by the a be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	ume or death 5					
Д.	s that ned b	by Pł	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
Vital Records,	w requires been sig should be	ed b						1 □ Y	es 2 No 3 □ Pr	robably 4 Unknown
ဝင္ပ	has bei	Completed						24a. Was a	n 24b. Were as	utopsy findings available completion of cause of
<u> </u>	The page	Com						perfori	med? death?	2 □ No
VIta	Ician; certific ector,	Be	25. Was case referred to medical examiner?	lospital: ,		1045	26. Place of Deat	h (Check only on	e)	
	Physician: The la this certificate har ral director, page 2	P.	1 Yes 20 No	1 Inpatier 28a. Date of Injur			4 Nursing Ho		ence 6 Other (Spe	cify)
on	ding Ph h. After thi funeral	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day		Wor	k? K? Yes 2 □ No	200. Describe no	w injury occurred	
Division or	after death after death Director: /	fica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju	ry - At home, farm, str			28f. Location (St	reet and Number or Ri	ural Route Number,
	tal or s afte al Dir ed in	Certification:	4 [] Hornicide	building, etc	. (Specify)			City or Towi	i, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	edical (29a. Certifier Check only one) Certifying Physical Exami	sician: To the best oner: On the basis of and manner state	examination and/or in	n occurred at the til vestigation, in my o	me, date and place, ppinion, death occu	and due to the c rred at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number		9d. Date signed (Mont	
			> SBortin	DOCTOR		Res	001	S	eptember 6	, 2007
	3	Ì	30. Name and address of person who co			Print)	1			
			SAIRAH BASHIR, H	arbor Hesp	r's Signature	Scuth	Hanover S	treet, Bo	althore M	aryland 2125
8	Sta Registr	-	SEP 1 3 200		A AM	and s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29328 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2007 12:30 A M september Frances P. Argabright 4a. Facility Name (If not institution, give street and number) 4c. County of Death Glen Burnie Baltimore Washington Medical Center Anne Arundel If Under 1 Year If Under 24 Hrs Months Days Hours Min 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🛛 F Yrs 219-10-5908 10/9/09 Tennessee Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Pasadena Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 809 Pasadena Road USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2. No 1 ☐ Yes 2 No Specify: Specify 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hiley F. Ousley Francis M. Irwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Sue Liberto / Daughter 809 Pasadena Road Pasadena , Maryland 20a. Method of Disposition 20c. Location - City or Town, State Ba Ictriano riema on emiastrator 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State @ Loudon PArk 9/12/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTEVE DARS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying

Physician /Medical Examiner

Department of Health a Important: If item 27 is any injury or other tra

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

items

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natural

Director

Funeral

Completed by

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Hygiene. the

and Mental Hygie is marked other

Baltimore, Maryland 21215-0036

ours after death.
neral Director: /

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

by Physician/Medical Be Completed Certification: To

Medical

State Registrar 29b. Signat

Cause (Disease or injury that initiated events resulting in death) Last	c. TYPSRTSWS FW Due to (or as a consequence of):	YEARS
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ■ No 9 ☐ Unknown	1 ive hirth 2 Fetal death 3 Sctonic pregnancy	Date of delivery Month Day Year
ACUTE RSMA	1 Yes 2 No	ontribute to the cause of death? 3 □ Probably 4 □Unknown b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ♣ No
25. Was case referred to medical		TLITES ZEPNO
examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 C	Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		urred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nur City or Town, State)	mber or Rural Route Number,
29a. Certifier 1 Certifying Pt	iysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and	manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

PATAC DARK OCEN BURNER

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

within 24 hours a To the Funeral C

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 5, 29c, d per fh/dr., 281, 09/13/07dhb

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sakina Bano Sveda 27 2007 12:55a /Medical August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick 7081 Bradshaw Court W Frederick If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months 1 M 2 F 83 Director India 1924 June 15 Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Meclical Examiner must be notified at MD Frederick Frederick 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7081 Bradshaw Court W 21703 Pakistan Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ Specify: Specify: white 3 ☐Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglen Important: If Item 27 is marked other this any injury or other traumatic event, the once. homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sved Naseer Uddin Salma Begum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7081 Bradshaw Ct. W. Frederick, MD 21703 19a. Informant's Name/Relationship (Type. Print) 7081 Bradshaw Ct. W., Frederick, Syed I. Ahmad (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Lake View Memorial 8-30-07 Sykesville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Paige Haight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End stage Renal Disease Immediate Cause (Final **Physician** YE ARS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, fany line in the increase cause. Enter Underlying Cause (Disease or injury Due to (or as a conse juence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last physician ar s the burial-t Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Honknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy 1☐ Yes 2 No To the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2[] No Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of Injury (Month, Day Year) 28h. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:,
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 11, 2007 D0062223

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PLAYEKN BY MUN, 1967 THRAS TOHNISH DRIVE, FREIENCE, MD - 21702.

32 Registrar's Signature

		•	For State Registrar	State of N	Maryland	d / Depa <i>Cei</i>	artment of tificate of	Health and f Death	d Mental H	ygiene Reg. No.	2007	29330
			1. Decedent's Name (First, Middle, La	st)					2. Date of Month	Death Day	Year	3. Time of Death
	Physicia /Medic		Norman J. Bowma	ker					Septer			9:00 P ^M
).	Examin		4a. Facility Name (If not institution, give	e street and numbe	r)			or Location of De	eath	4c.	County of Death	
			The Atrium Vil 5. Social Security Number 6.5		Age (In yrs. la	et hiethdaul	Owing	s Mills	Hrs. 8. Date of I		Baltimor	e place (State or Foreign
	Funeral Director			1025 M 2□F	82.	Yrs.	Months Day		lin. (Month,	Day, Year)	Cor	ntry) York
-			091-24-7354 Usual Residence of Decedent		0.4				12/1.	0/24	New	
	how		10a. State 10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Limits
	Ba-f	Director		imore	Ow	ings 1	Mills					1 ☐ Yes 2 SNo
	vith th	Die	10e. Street and Number				10f. Zip Code				zen of What Cou	intry?
	s 23s	eral	4730 Atrium Cour	t 12. Was Deceder	at Ever in 11 S	12.1	211		/Specify Ves or	US	SA 14. Race - Amer	ican Indian
	ter de	Funeral	11. Marital Status 1 Never Married 2 Married	Amed Force	s?	. 13.	f Yes, specify Cu	f Hispanic Origin? Iban, Mexican, Pu	uerto Rican, etc.)	140	Black, White	
980	hours after death with the Maryland Jural', or tlems 23a or 28a-f ehow at Examinar must be notified at	ğ	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates	_		1 □ Yes 2 /⊠ N	o Specify:			Specify:	Thite
5 0	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	ient's Usual Occ	upation e during most of	working	16b. Kir	nd of Business/li	ndustry
21	hen.	du	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. i	DO NOT use reti	red)		D = 14	co Con	& Electric
N D	filed within 72 Hygiene. other then "nal ent, the Medic		12 17. Father's Name (First, Middle, Last	4		Exec	utive vi	Lce Pres:	Laent Name (First, Mide			d liectife
Maryland 21215-0036	e d fa	To Be	Russell John Bo					Cora			,	
аZ	shou ind M in mer	-	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Stre	et and Number or		nber, City o	r Town, State, Z	ip Code)
	ges 1 and 2 should t of Health and Men if item 27 is marke or othar treumatic		Corinne T. Bowmak	er / Dau	ghter	20 Am	berlady	Court	Owings M	ills,	Marylan	nd 21117
ore	ges 1 a of of He or oth		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □	Removal from Stat	Ba La	ace of Dispo	sition (Name of		Date	ki.	cation - City or 1	
Ě	Pages ment of lant: If it		4 □ Donation 5 □ Other (Speci	(v)	. @ I	Loudon	Character Section 1		11/07	_		Maryland
Baltimore,	permit. Page Department Important: If eny injury o		21. Signature of Funeral Service Lice	t Car	1	//		lress of Facility Lkens Av				
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	polications that caus	ed the death.	. Do not ent	er the mode of d	ying, such as care	diac or respirator	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Severe	du inf	Pairec	lett ve	ntricula	r cont	ractil	ity	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a conseque					sel I		
I	LAdiffici	7.	Sequentially list conditions,	b. Sever	as a conseque		ry ar	ery dis	sease u	MAC.	(ct mas	
	uted I	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	220 10 (0.1		01100 017.	previou	5 - Inyu	arana	111100	10015	
o	exected and and rial-tra	Exa	resulting in death) Last	Due to (or a	as a conseque	ence of):						
8760	The law requires that the death certificate be executed tie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dlcal		d								
9	ertifica ling pl	1001	IF FEMALE:	00- 16			····					
Вох	leath certific attending p I for use as t	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1☐Live birth 4☐Pregnant	2 Fetal	death 3	Ectopic pregnar Other (specify)	псу		4	23d. Date of deli- Month	very Day Year
o	that the de ned by the a detached t	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			J Other (specify)					
ď.	es that igned b be deta	by Pi	Part II. Other significant conditions	contributing to death	but not resul	Iting in the u	nderlying cause	given in Part I.	23e. D	d tobacco u	se contribute to	the cause of death?
ğ	w require been sig should b	ed							1	∐Yes 2∫	ZNo 3□Pro	obably 4 Unknown
ဝင္ပ	e law re has be ge 2 sho	Completed							24a. W	itopsy	24b. Were au	topsy findings available ompletion of cause of
<u>=</u>	: The cate h	S							pe 1 □ Ye	nformed? s 2 No	death? 1 ☐ Yes	2010
<u> </u>	ector rector	Be	25. Was case referred to medical examiner?	Hospital:			_ (Thac	Death (Check on			
ō	Phys rthis ral dii	. To	1 Yes 2 No	28a. Date of Ir		PVOutpatier 28b. Time o	IL SEL DOA	4 LI NUI SIII	g Home 5			erfy)
5	Attending Physician: r death. ector: After this certific. by the funeral director.	tlor	1 ∠Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	l M	lork? □Yes 2□No				
Division of Vital Records,	r Atten er deat rector: by the	Certification;	3 Suicide 6 Could not to determined	286. Place of	Injury - At hor etc. (Specify)	me, farm, str	eet, factory, offic	e e	28f. Locatio City or	n (Street an Town, State	d Number or Ru)	ral Route Number,
۵	ital or A											
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 ☐ Certifying P (Check only 2 ☐ Medical Exa	hysician: To the be miner: On the basis and manner	of examinati	vledge, deat ion and/or in	n occurred at the vestigation, in m	time, date and pi y opinion, death o	lace, and due to t occurred at the tim	he cause(s) ne, date and	and manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	7//	11/	21/1	29c. Lice	nse number		29d. Dat	e signed (Monti	n, Day, Year)
•	1		- Conc	as as	100	VOCE		31476		Septe	ember 10	, 2007
1	2		30 am and address of person who	/			•	duc 01/	TT	M	-11 01	204
	Sta	ite.	James Douglas Cla 31. Date filed (Month, Day, Year)	32. R	strar's Signati	ure		ite 214	lowson	, mary	1and 21	. 204
	Registr		SEP13		see)		carle					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2007 29331 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** :30 PM September 8, 2007 <u>James E. Baxter</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5/15/45 **Funeral** 1**¼**M 2□ F Yrs. 62 Director 215-44-0024 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 □ No rector MD Baltimore n/a within 72 hours after death with the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ā 21230 USA 1129 West Ostend Street Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Š 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Utility Installer 0 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any lighry or other treumatic event 2008. Be William Sewell Baxter <u>Edna Bonalyn Jordan</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21230 1129 West Ostend St. Wife JoAnn Baxter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Backetelling) Backetelling (Name of Backetelling) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 9/11/07 @ Loudon Park Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Lidensee 22. Name and Address of Facility Loudon Park Funeral Home Baltimore, Maryland 21229 3620 Wilkens Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 7-8 months Pancreatic Adeno Carcinoma /Medical Due to (or as a consequence of): Examiner 4-5 months Peritoneal Carcinomstosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed -transit and Due to (or as a consequence of). physicien ar Box 68760, ician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 3 Probably 4 □Unknown Type 2 Diabetes Mellitus 1 ☐ Yes 2 ☐ No been sign Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ⊀ No page 2 s certificete has 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 N npatient ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: or Attending Injury 1 Natural 5 Pending To the necessaries after death.

To the Funeral Director: After the funeral necessaries. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital Fertifying Prysisian: To the best of my knowledge, death occurred at the time, date and place, and due to the eause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 39s Cartifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD P-19508 September 8, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Ave, Baltimore, Maryland 21229 Awais Masood 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP13 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** September largaret - 07 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, 12/22/ Homore Johns Hopkins If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 💢 F 219-32-2660 68 1938 N. CAROLINA Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location notified at X☐Yes 2☐No MD N/A BALTIMORE CITY Funeral Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 21205 USA 925 N. BROADWAY death ıral", or items 2 I Examiner mus 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hydjene.
Int: If item 27 is marked other than "natural", or iten iny or other traumatic event, the Medical Examiner iny or other traumatic event, the Medical Examiner. 1 ☐ Yes ANNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: BLACK Completed by 3 Widowed Wivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) US SOCIAL SECURITY Elementary/Secondary (0-12) 12TH College (1-4or 5+) ADMINISTRATION COOK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES TURNER LOUISE HOLLAND ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YVETTE BUTLER / DAUGHTER 3671 FOREST HILL ROAD, GWYNN OAK, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State METRO CREMATORY 9/17/07 CATONSVILLE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Euneral Service Licensee OW Z dise, or complications that caused the death. Onot enter the mode of dying, such as cardiac or respiratory arrest, fre. List only one cause on each line. 4600 LIBERTY HEIGHTS AVE., BALTIMORE, 23a. Par Enter the dis-shock, or heart fail Immediate Lause (Final disease of condition Approximate Interval Between Onset and Death Physician Bacteremia days disease of condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 Onknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No 24a. Was an autopsy performed 1 Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Peath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No death. Director: d in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a

State Registrar Medical Doctor

Johns Hopkinsto 30 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANC

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

Spital, 600 North Wolfe Street, Baltimore, MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29333 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2306 JOSEPH L. BYRNE September 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Ballmore N/A Sirai Itospital Balfimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□F Director 215-50-3073 MARYLAND 12/22/1948 58 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD BALTIMORE TOWSON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 1312 COLBURY ROAD APT. G 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 Divorced "natural", WHITE Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. 4 YEARS Elementary/Secondary (0-12) the SALES RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH A. BYRNE MINNIE LOUISE RILL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. CHARLES J. REIP/COUSIN 1006 SHAFFNER DR. BEL AIR, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) MORELAND MEM. PARK 9/13/2007 HILLENDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a; art1. Enter the diseast, or combigations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or as a consequence of): **Physician** disease or condition resulting in death) 8 respirating /Medical Examiner how equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pulmonery 1 ☐ Yes 2 No 3 Probably 4 Unknown ensjon 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy perform r this certificate haral director, page 2 **1** No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 (Inpatient P 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Death 2 Decident s after death.
I Director: After to a in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division or Vital Records, P.O. Box 68760

Effect town as Joseph Baltimore, Maryland 21215-0036

To the Hospital o within 24 hours aft To the Funeral DI completely filled in 0

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Satrift Bosc 31. Date filed (Month, Day, Year) SEP 1 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 0

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** MON Hember 10,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A University Mediral trucke Manjard 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Dec. 17,1933 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Hours Maryland 1**∭**M 2□F Director 212-32-5289 73 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Pasadena Director Maryland Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 221 Dale Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decadent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ss 1 and 2 should be filed within אל Health and Mental Hygiene. Item 27 Is marked אירים ידים Elementary/Secondary (0-12) College (1-4or 5+) 12 O Road Construction Inspector State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 01ga Jonsen Η. Jr. 2 Byron Charles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) 221 Dale Road, Pasadena, Maryland 21122 Alberta J. Byron permit. Pages 1 and Department of Heatit Important: If item 27 any Injury or other t once. other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Park 09-15-07 Elkridge, Maryland 21. Signature of Fundral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. The 3204 Mountain Road, Pasadena, Maryland 21122 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pidural /Medical Due f (or as a consequence of) Examiner asthenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner the burial-transit Due to (or as a consequence of) Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of page death? 1 ☐ Yes 2 No 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ed by the a has certificate Hospital or Attending Physician: After this death.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
completely filled in by the To the I

State

Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Year)

32. Registrar's Signature

Ball Man

MO

29c. License number

sene

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND THE 19a, per INF., 6371, 9/26/07, WS

State of Maryland / Department of Health and Mental Hygiene 077 29335 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 Year Cecelia Sept 9, Rebecca Banks 3:45AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Clinton Nursing Home Clinton Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Rountry Price (Month, Day, Year) April 17, 19 26 Washington 5. Social Security Number 1 □ M 2 1 579 32 4124 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Prince George Clinton 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 9211 Stuart Lane 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Packer Sydner Potato Chip 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thornton M. Banks Mary Edelin 19a. Informant's Name/Relationship: (Typa Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Lanham (Daughter) 7708 Dyson Road, Brandywine, MD 20743 20b. Place of Disposition (Name of commetery, crematory or other place) Sept 12, 2007 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery 21. Signature of Funeral Sance Ucansee 22. Name and Address of FacilityLee Funeral Home, Inc6633 01d Alexandria Ferry Road, Clinton, MD 20735 moo257 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CHRMIC OBSTRUCTION Long Dissure disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 Vilo 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Nio 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 40 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit O. Box 68760, signed by the at d be detached fo Division of Vital Records, P. this After death. within 24 hours after deal To the Funeral Director: To the

Physician

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Examiner

Funeral

Director

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Itams 23a or 28a-f ehor ingrimust be notified at

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

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Certification: To

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31. Date filed (Month, Day, Year) State SEP 1 3 2007 Registrar

(Check only one)

29b. Signature and title of certifier

liAm

ANNER 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

anen

29c. License number

D37206

29d. Date signed (Month, Day, Year)

September 10, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 200 **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** HOSPITAL OURS MORE Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director NGAS 10e. Street and Numbe 10g. Citizen of What Country? 108 BO US A BALISONG Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) Work E 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Philippines HOLEY LAND 22. Name and Address of Facility Ph. 111 P A. WEAT NERFORD FF 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Whitnown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed' To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 V 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0030355 30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of MEN and Pobla Garden of the alth and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 2007 September 11. 9:10 Harold M. Backhaus 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Oakcrest Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 216–20–0760 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**M** 2□F Yrs Maryland 84 6/30/23 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 1 ☐ Yes 2 No Parkville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 1309 Westwood Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Civil Engineer City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Niegsch Albert A. Backhaus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gary Backhaus / Baltimore, Maryland 21239 6621 Parkway Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park Cemetery 9/17/07 Baltimore, Maryland
22. Name and Address of Facility Loudon Park Funeral Home Loudon Park Cemetery 9/17/07 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1 Fm of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non small 0011 long concer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Digeas e 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 10 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 Department of Health ar Important: If item 27 is any injury or other trau Physician /Medical Examiner 11.03 74Roco Records, Division or Vital ACKHAUS To the Hospital or Attending death. within 24 hours

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

other traumatic event, the Medical

than

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Director

Funeral

Completed

Examine

Physician/Medical

δ

Completed

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Certification:

Medical

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

mon:

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2007

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Make and

32. Registrar's Signature

the attending physician and the for use as the burial-tran-

page 2 should

this certificate has

To the Funeral Director: After th completely filled in by the funeral

Registrar DHMH 17 Rev 1/2001 Wa

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2007 29338 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Kose, Bradsher 2nd 10:35 PM 2007 ept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimove
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. University of Maryland Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, O7 O2 Birthplace (State or Foreign Country) **Funeral** Year) 1 ☐ M 2 💢 F Director 35 72 WV 234-56-9725 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at 1 X Yes 2 □ No MD NA Baltimore Director 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be ready. 21215 U.S.A. 5408 Wabash Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes Y☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: <u>ک</u> Black 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry
Baltimore City 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Administrator 6yrs Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၟႍ Pheola Smitherland John Curenton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5408 Wabash Ave, Baltimore, Md 21215 Ronnie Bradsher-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 9/10/07 Baltimore, Md of Funeral Service Licensee 21 Olynature 22. Name and Address of Facility
March F/H West Venald 21215 4300 Wabash ave, Baltimore, md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metabolic acidosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner issue ischemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner popertusion Istemic hy law requires that the death certificate be execut burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tailure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 1□ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Vinpatient 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number adura, M.D. AU4176435A18120 Kinberlee 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene Street Baltimore, MD 21201 Adkins, MD imberlee 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per fly 871 9-13-07 vt.
State of Maryland Department of Health and Mental Hygiene Certificate of Death Month 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2007 6:50 P M HELEN. **BERRY** 9 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 525 Stewart Ave Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1/29/1913 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 234-09-5372 1 □ M 2 🕶 F 94 Director Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 X No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 525 Stewart Avenue 21061 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ Ž∭ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes Z☐No Baltimore, Maryland 21215-0036 Specify: white þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk Clothing Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Sacchetti Antoinette Dono Frio ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Augie Patrick Berry/son 525 Stewart Ave Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Beverly Hills Cem. 09-13-2007 Morgantown, WV 22. Name and Address of Facility Singleton Funeral & Cremation Srv 21. Signature of Funeral Service Licensee 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MTRACRANIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERTBO Scale tidlly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day signed by the at I be detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 | Yes 2 | 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: A
d in by the fu 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled the Hospital 1 🔛 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) no

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SEP 1

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 7:40 AM HAROLD BERS 9 11 -07 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death MANOR CARE - DULANEY TOWSON BALTIMORE 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/28/1919 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 218-26-2663 88 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11 TANNER COURT 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 No USA Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **OPTOMETRIST** OPTOMETRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROBERT BERS LILLIAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 TANNER COURT, BALTIMORE, MD 21208 BERNICE BERS / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 09/12/2007 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1 /Enter the disease, or conficications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) andiomyopath Due to (or as a consequence of): ascular dissessi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events hronic resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 1□ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

certificate be executed

Division or Vital Records, P.O.

or Attending

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or dical Examiner must be

other traumatic event, the Medical

h and Mental

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is in any Injury or other traum once.

e filed within 72 hours after all Hygiene. I Other than "natural", or iter

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

2

attending physician and for use as the burial-trar Physician/Medical ed by the a þ Completed certificate has b irector, page 2 sh Be Certification: To After this after death.

Director: Af
in by the fur

23b. Was decedent pregnant in the past 12 months? 9 Unknown

and manner stated.

25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No 27. Manner of Death

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 5 ☐ Pending investigation Injury

28c. Injury at Work?

28d. Describe how injury occurred

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Timonium, MD 21093 Asach 206. Timeniun rd. # 209 31. Date filed (Month, Day, Year)

State Registrar

filled in by

completely

Medical

24 hours a Hospital

within 2

6 Could not be determined



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend State of Maryland 1887 art men 2014 and Mental Hygien 2017

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** 1:000 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Kandallstown 110 Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10M 20F 47Yrs. ntry Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 Tares 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married | ☐ Yes 2 ☐ Mo | Yes, Give | Year or Dates: 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Olivia Pue ု 19a. Informant's Name/Relationship (Type,, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is eny lojury or other trainone. Hank Olivia 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 Dourial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility Approximate interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 50051 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 0,0 Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Winknown 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificete 1 🗌 Yes 2 1 No 1 Yes 2 No 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Il Director: After this id in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Mann f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 - Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2600 ADEN EMI SOSAMY A LIBERTY 14614117 32. Registrar's Signature ma 21215 31. Date filed (Month, Day, Year) State SEP 1 3 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day **Physician** POUA M 2 2007 DENISE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAIHMER ENTER /ourson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2DF MAY 78 50 Director 7376 20 Any JAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Yes 2 No Director BALHUIE MAMIANA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/2/5 USA EVIN DALE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 250 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Plack 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bonlo MARGGEV 24 GAYS 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ပ MANA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2 2 9 19a. Informant's Name/Relationship (Type. Print) Pens HUCBAND Bothman Rel OLD COBB Frenericle AWES 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 12 Surial 2 □ Cremation 3 Removal from State 87 WOUDLAWN, / nory laws 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service Licens 22. Name and Address of Facility CHATOTAL-KEIS TENFOUR RÅ Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gudometrul **Physician** years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS PLL 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58303 otenber 12 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARIES ST 6707 N. Charles Conson und 31. Date filed (Month, Day, Year) 32. Registrar's Signature 13 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17

Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Annette Cirigliano 8:06^{a м} 10, 2007 September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Social Securify Number 091-12-3535 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year 9/30/1913 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2X F 93 Director Usual Residence of Decedent 10c. City, Town or Location 10b. Count 10d. Inside City Limits MD Montgomery Rockville 1 ☐XYes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 USA 299 Hurley Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Nidowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Angelina Labriola Joseph Laino ပ္ 19a. Informant's Name/Relationship (Type. Print)

Donna E. Leach / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Boyds School Road, Gettysburg, PA 17325 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/19/2007 Flushing, NY Mount Saint Mary's 4 Donation 5 Other (Specify) Ceme be trye and Address of Facility
Charles L. 21. Signature of Funeral Service Licensee Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) **Examiner** nen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔼 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an has autopsy perform 2 No 1□ Yes in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? after death. Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAYED ELSAYYAD 97/5 Medical Centre Dr. Rocknille, MD 80850 ar's Signature 31. Date filed (Month, Day, Year) State SEP 1 3 Registrar 2007

Certificate of Death

Reg. No. 2007

2007

n/a

4c. County of Death

Day

04

USA

21286

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

MARYLAND

14. Race - American Indian

Black, White, etc.

Specify: WHITE

23d. Date of delivery

Day

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Year

Month

Baltimore

5 : 51 A M

2. Date of Death

Month

09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

32. gistrar's Signature

Samaritan

31. Date filed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

NANCY L. COCHRAN

Physician

/Medical

Registrar

State

5601 Loch Raven Boulevard

07-07048 **UNK UNK**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 29346

		1- For State Registrar	Cert	tificate of L	Death			Reg. N	o.		
Physicia		1 Decedent's Name (First, Middle,Last)	_				2. Date of	Death			ne of Death
ledical Exami		Diekia T.	Davis				Month Septe	Day 10 mber	y Year), 2007	11	38 hrs
		4a. Facility Name (if not institution, give		4b	. City, Town, or L	ocation of Death			4c. County of	Death	
		5801 Baltimore National Pik			Catonsville		47		Baltimore	County	
		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year	If Under 24Hrs	s 8 Date	of Birth/M			(State or
Funeral Director	- [2 7		st birtilday)	Months Days	Hours Min		•	1	Foreign (a Country)	tulail
Director		213-13-7024 101	1 24 21	Yrs.	,-		Au	9 18	1986	Country)	Trand
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any		10a. State 10b. County		Town or Location							nside City Limits
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th th		2010 Druid	ALL The		212					2:11	
h wi	ers	. —	12. Was Decedent Ever in U.S Armed Forces?		Decedent of Hisp s, specify Cuban,				14. Race - White,	- American Ind . etc.	dian, Black,
deat or ite	Funeral		1 Yes 2 L No					,		21-1	
after al",	b	3 Widowed 4 Divorced	f Yes, Give Year or Dates:	1 Y	es 2 L No	specify:				Black	
ours atur	9	15. Decedent's Education (Specify only	highest grade completed)		Usual Occupation			16b	. Kind of Bus	iness/Industr	y
72 h	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)		t of working life. [JO NOT use rec	illed) ;		11		
136 thm	림	GED		Nu	rse's	4ide	,		Ite	alth	
5-0036 led within 72 Hygiene. other than other Medical	Comple	17. Father's Name (First, Middle, Last)				3.Mother's Name	e (First, Mid	ldle, Maid	en Surname)		
215-0036 be filed within 7 ttal Hygiene. ked other than ent, the Medica	Be (Matthew Sla	ade			Thoma	Sino	· 1	Davi	(•
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	일	19a. Informant's Name/Relationship (Type		19b. Mailing A	Address (Street				City or Town	, State, Zip C	ode)
MD d 2 sho (th and n 27 is		Theodore Davi.		34	S. Corr	ollton	A	re T	3014	ul	21223
· · · · · · · · · · · · · · · · ·	•	20a, Method of Disposition		Place of Dispositi	on (Name of cem		Date		c. Location -	City or Town,	
Baltimore, MD 21215-003 pemit Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med				rematory or othe	r place)					1 1	
more Pages 1 nent of H ant: If		4 Donation 5 Other Specify:	N	w Cath	edral C	em 9-	17-20	007 1	Sulto	, led	-
Balti Permit Departi Import		21. Signature of Funeral Service License		22 No.	ma and Addraga	of Facility	so Fue	ral	Servic	e P.A.	
E 5 2 00		(aslon C. D	onlan		701 A.C.C	11019 31	F. Ba	lto.	hd. 2	1217	
Physician		23a. Part I. Enter the disease, or complic	cations hat caused the death.	Do not enter the	mode of dying, s	uch as cardiac			shock, or hea	rt App	roximate Interval
/Wedical		failure. List only one cause on eac		o trauma						Bet	ween Onset and Death
xaminer			sphyxia and blunt force ue to (or as a consequence of			-				_	
		b		,.							
	ē	Sequentially list conditions, if any, leading to immediate D	ue to (or as a consequence of):		Set ex				770	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						-			
, b' = =	ха	events resulting in death) Last	ue to (or as a consequence of):							
trans		d									
ficate be executed g physician and the burial - trans	/Medical	UNPENDED	AMENDED								
760, ficate by g physic	ě	IF FEMALE:	23c. If yes, outcome of pregr	nancy		_			23d. Date of	ldelivery	
787 rtific ing p	اڇَ	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	I death 3	Ectopic pregn	ancy		Month	Day	Year
lox 687 leath certific e attending p	siciar		4 Pregnant at time of dea	ath 5 Othe	er (Specify)			_ 1			1
Bo dea	Phys	1 Yes 2 No 9 Unknown	g Unknown								
P.O. B that the daned by the	颪	Part II. Other significant conditions	contributing to death but not re	sulting in the un	derlying cause gi	ven in Part I.					use of death?
ires that signed I be deta	d by						1	Yes 2	∨ No 3	Probably	4 Unknown
ds, equii	Completed	5				-		Was an			findings available
law r	힐							autopsy performed		rior to comple eath?	tion of cause of
Zec cate	팃							Yes 2		✓ Yes	2 No
ital Recition: The secrificate rector, page	Bec	25. Was case referred to medical				of Death (Check	only one)				
/it	e B	examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other Nursi	ing Home	5 Res	idence 6 🗸	Other: Scen	е
ing Ph After t uneral	-	27. Manner of Death	28a. Date of Injury	28b. Time of Inj	ury 28c. Injury	at Work?			injury occurre	ed	
ion (tending eath.	힐	1 Natural 5 Pending	FOUND: Day, Year)	FOUND:	1 Y	es 2 🗸 No	Subject	assault	ted		
Sic Atte r dea ector	g	2 Accident Investigation	Sep 10, 2007 28e. Place of Injury - At ho	1132 hrs	factory office bu	ilding etc	28f Loca	tion (Stree	et and Numbe	er or Rural Ro	ute Number, City
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not be determined	9				or To	own, State)		
Spitz spitz hours nera	Ö	4 Momicide	(Specify) Hotel/Mote				1				tonsville , MD
To the Hos within 24 h To the Fur completely		29a. Certifier 1 Certifying Physicia	n: To the best of my knowledg	ge, death occurre	ed at the time, dat	e and place, an	d due to the	e cause(s)	and manner	as stated.	(2)0:
To th vithii To th ompl	Medical		On the basis of examination are and manner stated.	iu/or investigatio			at trie time,				
	ž	29b. Signature and title of certifier	1		29c. License	number		29	d. Date signe	ed (Month, Da	ay, Year)
		101/11/11/	70		O.C.N	1.E.		s	eptember	11, 2007	
	ŀ	30. Name and address of person who co	ompleted cause of death (Hom	23a)							
\			tant Medical Examiner		Street, Baltir	nore. MD 21	1201				
'			22: Degistraria Cinnafi	-			-				
	_										
St Regist	ate	31. Date filed (Month, Day Year) 200	7 Mayer As	re Apple							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0105 Frederick Earl Dietz, Sr. reptember 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. Social Security Number **Funeral** Days Months Hours 1 XM 2 ☐ F Maryland 07/16/1921 Director 218-36-3752 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r 28a-f show notified at show 1 ☐ Yes 2 No Director MD Baltimore Glen Arm 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number o e Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. - P.O. Box 441 21057 U.S.A. ral", or items 23a Examiner must b 5728 Glen Arm Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 0 1 ☐ Yes 2 🛣 No Specify: White Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Year or Dates: 'natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Farmer Is marked other aumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Laudenklos ဂ္ Goedfrey Dietz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21057 19a. Informant's Name/Relationship (Type. Print) 5728 Glen Arm Road, P.O. Box 441 - Glen Arm, MD item 27 other tra Margaret A. Dietz (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If its any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdns: 09/15/2007 Bel Air, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 60 11750 Belair Road - Kingsville, Maryland as 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division or Vital Records, P.O. Box 68760, Vispital or Attending Physician: The law requires that the death certificate be executed. burial-tra Due to (or as a consequence of) Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 → Known Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1∐ Yes 2 100 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Impatient ို 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 h To the Fu 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) union OWIG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤊 🛭 🕽 🕇 Certificate of Death Reg. No. 3. Time of Death . Decedentis Name (First, Middle, Last) 2. Date of Death Monte Physician /Medical 4c. County of Death 4b. City, Town, or Location of Death acility Name (If not institution, give street and number) Examiner 8. Date of Birth (Wonth, Day, Year) 09-01-1916 9. Birthplace (State or Foreign Country) **Funeral** 233-40-7658 1 □ M 2 ▼ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 Yes 2 No r 28a-f sh notified Saltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 2206 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔏 No altimore, Maryland 21215-0036 Specify. Black 3 Widowed 4 □ Divorced er than "natura the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Keta Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Be 2 19b. Mailing Address (Stree and Number or Rural Route Number, City or Town, State, Zip Code) Balto. 632 Ave. 20b. Place of Disposition (Name of 20c. Location - City or 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Maryland 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dehydration /Medical Due to (or a consequence of): **Examiner** omitina Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conservatice of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ artery disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No fibrillation 24a. Was an certificate has b irector, page 2 sl autopsy perform Stroke 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ☐ ER/Outpatient 3 DOA Medical Certification: To 6 ☐Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 🗌 Yes 2 🗆 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 (Check only one) 29c. License number 29b. Signature and title of certifier D0062735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Blvd, Baltmore, 5601 Aparna Jonna 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

1 3 2007

SEP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Amend 12, perFH, G871, 9/13/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 12:30 AM 2007 /Medical 4c. County of Death 4a. Facility Name (If pot institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore KoKo 35 Ser If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 □ South 38-126 Director Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Des 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 A If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Blac þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use jetired)

NU SE 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ewar. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltin Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Service Licens 22. Name and Addr 23a. Part1. Enter the Iscase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) unknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a Records, P.O. 1 ☐ Yes 2 Z No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 1□ Yes 2 No Vital Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ö 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number Member 11,2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 N. Eutaw 21201 Hospice

State

Registrar

31. Date filed (Month, Day, Year)

5

32 Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Month EDENTON 1814 PM ALBERT September 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTFMORE JOHNS HOPKERS BAYUTEN MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F 218-07-2258 93 Director May 14,1914 Virginia Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2621 N. Snyder Avenue 21219 USA Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Millwright Maryland Slaq Co. 1 year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dosia Dillard James O. Edenton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Edenton son 2621 N. Snyder Avenue, Edgemere, Maryland 21219 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 13, 2007 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P. 7110 Sollers Point Road, Dundalk, Md. P.A. 21222 tho complications that caused the death. Connot enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease of shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metabahi Acidosis **Physician** 3 de /Medical Due to (or as a consequence of): Examiner Sepsit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner C. Ditt. 3 days Culitis requires that the death certificate be executed burial-tran Due to (or as a consequence of) or Vital Records, P.O. Box 68760, physician Physician/Medical the for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9∏Unknown 9 T Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş pe 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Gastro intestine bleed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autonsy perform Arter Disesse Wrong certificate 1 Yes 2 No Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this сотрете filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attend within 24 hours after death To the Funeral Director; 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) SEP 1 3

29b. Signature and title of certifler

30. Name and add of person who completed cause of death (Item 23a) (Type, Print)
Kewin Groszkouski, MD 4940 Eastern Avenue, Baltimore, MD 21224 Groszkowski, MD 32. Registrar's Signature 200

MD

29c. License number

D0066086

29d. Date signed (Month, Day, Year)

September 12, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		-	For State Of Wally State Registrar	Ce	rtificate of L	eaith and iv Death	Re	eg. No. 200	7 29351
j.	Physicia	an l	1. Decedent's Name (First, Middle, Last)				Date of Deat Month	Day Year	
	/Medic	al	LuMae V. Eckardt		4b. City, Town, or		Septembe	er 11, 200	
	Examin	er	4a. Facility Name (If not institution, give street and number) Charlestown Care Center			nsville		Balti	
1,420	Funeral		5. Social Security Number 6. Sex 7. Age (III	n yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	irthplace (State or Foreign Country)
	Director			89 Yrs.			10/17/	/17 Ma	ryland
	land ow it		Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary I-f sho fied a	tor	MD Anne Arundel	(Crownsvill	Le			1 □Yes 2 No
	th the	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What 0	country?
	ath w	ral	834 Hollywood Blyd.	-:-110 112	210		pocify Ves or No-		SA nerican Indian,
	iter de	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give		Was Decedent of His If Yes, specify Cuba		Rican, etc.)	Black, Wh	
	ours af	þ	3 Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	White
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the M. ciral Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupa e kind of work done o DO NOT use retired	ation Juring most of work	king	16b. Kind of Busines	s/Industry
7	within ene. than '	dm	Elementary/Secondary (0-12) College (1-4or 5+) 1 2 O	ı	cal Secret			Hospi	tal
V D	filed Hygid Sther ent, th	Be Cc	17. Father's Name (First, Middle, Last)	, mean	Jan Boole		e (First, Middle, I	Maiden Surname)	.=
0	uid be Mental rrked o	To B	Marian lowman				Purdy		
<u>a</u>	2 sho and h is ma		19a. Informant's Name/Relationship (Type. Print)					r, City or Town, State	
≥ u`	1 and lealth em 27 ther tr		Albert M. Eckardt / Son 20a. Method of Disposition		Hollywood losition (Name of ematory or other plac			11e, Mary1	
2	ages ant of l t: If ite		Burial 2 Cremation 3 Hemoval from State			1	.4/07	Roltimor	e, Maryland
Daltillion	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenses	HOUGOIF F		is of Facility $ { m L}_{ m C}$	udon Par	k Funeral	Home
ŏ	permi Depar Impor any Ir							ore, Maryl	
			23a. Part Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	e death. Do not er	nter the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ancres	1.(ancen			-
	Examiner		Due to (or as a c	onsequence or):					
ħ.		ner	Sequentially list conditions, if any, leading to immediate course. Either Underlying	onsequence of):					
	ecuted ind transit	ami	that initiated events c.						
Ĉ,	be exician a	al E	resulting in death) Last Due to (or as a c	unsequence or).					
09/00	iclan: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	edical Examiner	d						
X D D	th cert ending r use a	M/ue	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf 1 □ Live birth 2		☐Ectopic pregnancy	,		23d. Date of o	delivery Day Year
ם כ	requires that the death cer een signed by the attendir nould be detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			Month	Day
Į.	that the		Part II. Other significant conditions contributing to death but it	not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
g,	quires n sign	d by					1 □ Y	′es 2 2 N o 3□	Probably 4 ☐Unknown
Hecords	aw rec s beel 2 shou	Completed					24a. Was a	an 24b. Were	autopsy findings available
	The law ate has b page 2 si	Com					perfor 1□ Yes	rmed? death	to completion of cause of 1? 'es 2 No
VItal	Physiclan: this certific	Be (25. Was case referred to medical examiner?		ont 3 DOA Oth	er.	ath Check onl or		
0	Phys	<u>۴</u>	1 ☐ Yes 2 ☐ No	2 ER/Outpatie	EIIL 3 DOA	4 Nursing F		dence 6 Other (S	pecify)
	Attending Phyrdeath. ector: After thi	tion	1 Natural 5 Pending (Month, Day) 2 Accident investigation	<i>(ear)</i> Injury		k? Yes 2∐No			
DIVISION	r Attendi er death. rector: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury building, etc.	At home, farm, s	street, factory, office		28f. Location (S City or Tow		Rural Route Number,
2	pital o urs aft eral Di		29a. Certifier Certifying Physician: To the best of	my knowledge de	ath occurred at the ti	me date and place	and due to the	cause(s) and manne	r as stated
	To the Hospital or A within 24 hours after To the Funeral Direction completely filled in b	Medical	(Check only one) 2 Medical Examiner: On the basis of e and manner state	xamination and/or	investigation, in my	opinion, death occi	urred at the time,	date and place, and	due to the cause(s)
	within To th	Me	29b. Signature and title of certifier		29c. Licens			29d. Date signed (M	
	1		/ mn		DY	777		zeptern	15,2007
	6 Y		30 Name and address of person who completed cause of dea	th (Item 23a) (Type	e, Print)	(are	(at	septerh insvill	U
	St	ate	31. Date filed (Month, Day, Year) - 32. Begistrar	s Signature					
	Regist		SEP 1 3 2007	B 0	houle				

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State	of Maryl		artment of F <i>rtificate of</i> .		l Mental	Hygier Reg. I	000	7 20352
i de	Dhysisi		1. Decedent's Name (First, Middle,	Last)					2. Date	of Death	Day Year	3. Time of Death
	Physici /Medic	_	Edna Ericson						SEPT	EMBE	R 5, 200	27 6:30F M
	Examin	er	4a. Facility Name (If not institution, Saint Josep			enter	4b. City, Town, o		ath ISON		4c. County of De Ba	ath ltimore
E W	Funeral			6. Sex 1 □ M 2 1√2 F		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	rs. 8. Date n. (Mon	of Birth th, Day, Yea	9. B	irthplace (State or Foreign Country)
3-	Director		217-12-6226 Usual Residence of Decedent	Λ	3	34 Yrs.			June	11,	1923 Ma	ryland
	how at		10a. State 10b. County		10c.	City, Town or Lo	ocation					10d. Inside City Limits
	e Ma Ba-f s	Director	MD Balt:	imore		Tows	on					1 ☐ Yes 2X No
	be filed within 72 hours after death with the Maryland ttal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	J Dire	10e. Street and Number 111 West Road				10f. Zip Code	1286		10g.	Citizen of What C	Country?
	er deatl items 2 ner mus	Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed F		n U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes erto Rican, et	or No-	14. Race - An Black, Wh	nerican Indian, nite, etc.
036	ours aft ral", or Exami	ρ	3 Widowed 4 Divorced	If Yes, G Year or	2 📉 No Sive Dates:		1 ☐ Yes 2 🎇 No	Specify:			Specify:	white
215-0036	in 72 ho 1 "natu fedical	Completed	15. Decedent' (Specify only highes	t grade completed		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w d)	vorking	16b.	. Kind of Busines	s/Industry
212	d with giene.	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)	boo	kkeeper			gr	cocery c	hain
and	uld be file fental Hy rked other tic event	Be	17. Father's Name (First, Middle, L Carl Ferdinand	•				18. Mother's N				
Maryland	id 2 shoul	2	19a. Informant's Name/Relationsh Rita Armacost/				ng Address (Street W. Roge:					, <i>Zip Code)</i> 1209
Baltimore,	permit. Pages 1 and 2 should be for Department of Health and Mental Himportant: If item 27 is marked of any lijury or other traumatic even once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🕅 Other (Sp.		n State	b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c.	. Location - City of	or Town, State
Baltil	permit. F Departm Importar any Injur		21. Signature of Frineral Sentine L		Direct		2 Name and Addre State Ana Baltimore			5 W. I	Baltimor	e Street
R			23a. Part1. Enter the disease or shock, or heart failure. List of	complications that	caused the d	leath. Do not en	ter the mode of dyi	ng, such as card	liac or respira	tory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. DEM	ENTIF	4						Onset and Death YEARS
	/Medical Examiner					sequence of): JS UCLE	:R					
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			sequence of):						
'n,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last		O (or as a con	sequence of):						
58/60,	cate be ohysicia the bu	edical		d								
рох е	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome pf pre		∃Ectopic pregnanc	M.			23d. Date of d	
о Э	the deat the attr	Physician/M	in the past 12 months? 1 □ Yes 2 ὧ No 9 □ Unknown		gnant at time		Other (specify)	,			Month	Day Year
1	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant condition	ns contributing to	death but not	resulting in the u	ınderlying cause giv	ren in Part I.	23e	. Did tobacc	co use contribute	to the cause of death?
ecords,	require								-			Probably 4 ☐Unknown
r	9 L 9	Completed							-	. Was an autopsy performed Yes 2	24b. Were prior to death	autopsy findings available o completion of cause of ?
N Ta	lysician: The sister of the director, pag	Be C	25. Was case referred to medical examiner?			I.e.		26. Place of D				7-
0	S : S	은	1 Yes 2 No 27. Mariner of Death		Inpatient e of Injury	2 ER/Outpatie		4 □ Nursing			e 6 □Other (Sp	pecify)
	Attending Physic deathector: After this by the funeral di	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation (Mo	onth, Day Yea		Wo	rk? Yes 2 □ No	20d. Des	clibe flow ii	ijury occurred	
DIVISION	al or Attending Ph s after death. Il Director: After th ed in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	200. Plac	ce of injury - / ding, etc. (Sp	At home, farm, st	reet, factory, office			ition (Street or Town, St		Rural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical (Examiner: On the			th occurred at the tinvestigation, in my					
	To the To the Company of the Company	Me	29b. Signature and title of certifier	1			29c. Licens			29d.	Date signed (Mo	onth, Day, Year)
}			In	My X	3m	-		15452			1/4/0	1
			30. Name and address of person v		term on term			ግግርግ የ.1 ርዓ ርዓ ነ	NI MA	מעו עא	/ / dry mamm	1/1
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's S		R DRIVE	LOWBUI	14 <u>4 1716</u>	RYLA	ND 2120	1 4-p
	Registr	ar	OLT I O	2001	1800	85° 85						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept Day 200^{Year} **Physician** Edna Maureen Ellis 10 9:30 MP /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Fenwick Landing Asst. Living Waldorf 8. Date of Birth (Month, Day, Year)
1 an 10, 1922 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Washington DC 85 Director 578 38 0365 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2XXNo Waldorf Director Maryland | Charles County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20602 12814 Simpson Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes **②**No Specify White Specify. þ 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AFLCTO Insurance Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Edna Casson Cornelius H. Naughton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 734 Irvington , Virginia Maureen Lynch (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery Sept 17,2007 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Sign tur Funeral Service Licersee Alexandria Ferry Road, Clinton, MD 20735 Jours (1) Frank mo0257 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dangio carciolomo month Due to (or as a co use uence of): structive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 N → 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, physician attending pl for use as t Division or Vital Records, P.O. s certificate has b irector, page 2 s director, after death.

Director: / n 24 hound the Funeral Direction completely within 2. To the I 2

Physician

death with the Maryland

Baltimore, Maryland 21215-0036

r 28a-f show notified at

a or

ns 23a

10

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RITH B. Rita Jhaveri, MD 22335 Exploration Park Drive
Lexington Park, MD 20653 32. Registrar's Signature A Saldand

200

Theveir - MO

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

80032651

29d. Date signed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7

			For State Registrar	State of Ma	ryland				ealth and N D <i>eath</i>	/lental F	lygier Reg. N		2	3354
	Dhysisis		1. Decedent's Name (First, Middle,	,						2. Date of Month		Day Year		e of Death
	Physicia /Medic	al	DOROTHY ANNA ESS							SEP	Γ	9 2007		17 P ^M
	Examin	er	4a. Facility Name (If not institution, UPPER CHESAPEAK		ITFR			AIR	Location of Death		1	4c. County of Deatl HARFORD	1	
	Funeral			6. Sex 7. Age		ast birthday)	If Under	r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of	Birth	Q Riet	nplace (Sta	te or Foreign
- 6	Director		220~09~5097	^{1□ M 2} √F 88		Yrs.	Months	Days	Flours Willi.	(Month, Oct.	25,	1918 Mar	y land	
	and w	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation						10d. Inside	City Limits
	Maryl f sho	ō	Maryland Harfo	ord	K	ingsvi	lle						1 □ Y	es 2XXNo
	r 28a	Director	10e. Street and Number				10f. Zip	p Code			10g. 0	Citizen of What Co	untry?	
	th wit 23a o ust be	a D	821 Petem Rd.						087			USA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married XX Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 X N If Yes, Give Year or Dates:		1	Vas Dece Yes, spe □Yes		ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or Rican, etc.)	No-	14. Race - Ame Black, White Whate Specify:		•
₹203	72 ho natur dic 1	eted	15. Decedent' (Specify only highes	s Education t grade completed)	4	16a. Deced (Give	ent's Usu kind of wo	ial Occupa ork done o	ation during most of work l)	king	16b.	Kind of Business/	ndustry	
12	vithin "	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		oo not u Homen				Н	omemaker:	-Own F	lome
3- d21	filed v Hygie other t	ပ္ပို	17. Father's Name (First, Middle, I	- '			10111011		18. Mother's Nam	e (First, Mid				
-lan	should be fand Mental Fand Men	To B	Thomas Ellswort	ch Leonard					Anne C	atheri	ne J	ones		
e, Maryland	2 shot and N Is ma		19a. Informant's Name/Relationsh				-					y or Town, State, 2	lip Code)	
(a)	l and Health Im 27		William W. Essi	ig (Husband)	20h Pl	ace of Dison	sition (Na	me of	. Kingsv	Date		21087 Location - City or	Town, State	
000	Pages intent of H		XX Burial 2 ☐ Cremation	3 ☐ Removal from State	CE	emetery, crer (wood (natory or	other plac		4-07		ltimore,		,
999	nit. Pa artme ortant Injury		4 □ Donation 5 □ Other (Sp 21. 3 mature of Fun ral Service I		dik				sof Facility H		50	101111010,	1101	
G 88	permit. Departr Importa any Inja	(0)	Leather (1258chn			7401	Bela	ir Rd. B	altimo	re.	Md. 2123	6	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death	. Do not ent	er the mo	de of dyin	g, such as cardiac	or respirator	y arrest,		Approxi Interval	mate Between nd Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	ACUTE	MY	OCAR			FARCTI				Onset a	nd Dealif
_	/Medical Examiner		resulting in decary	Due to (or as a			770	0	48 NINV	Scur	* 60	DISEASE		
	STATE OF	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a					TKBCOV	JUNE		15(50), 5(
N	nd ransit	Examiner	tnat initiated events	с										
3	oe exe cian al	I Ex	resulting in death) Last	Due to (or as a	a consequ	ience of):								
96	cate be physicia the bur	edical		d										
2×	w requires that the death certificate be exective been signed by the attending physician and should be detached for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregna]Ectopic p	orognancy	,			23d. Date of de	-	
33.	e deatl he atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant et			Other (s				-	Month	Day	Year
8.	hat the od by ti detach	Phy	9 ☐ Unknown Part II. Other significant condition	ns contributing to death bu	ut not resu	ulting in the u	nderlying	cause giv	en in Part I.	23e. D	oid tobacc	co use contribute to	the cause	of death?
ds,	requires that een signed b nould be deta	d by		SRILLATION						1	☐ Yes	2 No 3 P	obably 4	☑ Unknown
Scord	law req as beer 2 shou	lete	HYPERTENS	5101							Vas an	24b. Were at prior to	topsy findi	ngs available
₹ <u>#</u>	The fav	Completed								p	utopsy erformed es 2 ☑	2 death?	2 No	or cause or
##	iclan: The lav certificate has ector, page 2	Be C	25. Was case referred to medical examiner?					l out	26. Place of Dea	th (Check or	nly one)			
0/6	Physic this c	မ	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatie		ER/Outpatier 28b. Time o			4 Li Nursing F			e 6 □Other (Spe	cify)	
Do (ding th. tuner	tion	1 Natural 5 Pending 2 Accident investig	(Month, Day	Year)	Injury	М	28c. Injur Wor 1 □	ḱ? Yes 2∐No	200.000		,,,		
DIMS	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		ury - At ho c. (Specify	ome, farm, str	eet, facto	ry, office		28f. Locatio City or	on (Street Town, St	t and Number or R tate)	ural Route	Number,
Essig	e Hospit 124 hour ie Funera	Medical (29a. Certifier 1 Certifyin (Check only one) 1 Medicel	g Physician: To the best of Exeminer: On the basis of and manner sta	f examina	wledge, deat tion and/or in	h occurre vestigatio	d at the til	me, date and place opinion, death occi	e, and due to urred at the ti	the cause me, date	e(s) and manner a and place, and du	s stated. e to the cau	se(s)
	To the within To the comp	Me	29b. Signature and title of certifier					9c. Licens				Date signed (Mon		to an
	, /		VNV+6.h	yanter	M			0 X	5017		Sti	TEMBER	. 10	7002
	7		30. Name and address of person	who completed cause of d		1 23a) (Type,		RTH	AVE	BEZ	411	R MD	21014	, -1
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registro		ture		-	.,, .		(1)			1
	Regist	rar	SEP 1	3 7007 1	55 0	13 B	12001	1						

07-06894 Carlton Ewell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 29355

		R	For State egistrar		ifficate of	Dealli	Reg. I	No	3. Time of Death
	Physician	n/ 1	. Decedent's Name (First, Middenset Carlton	dle,Last) Gregory		Ewell	Month Da September 4		2139 hrs
			a. Facility Name (if not institut 700 Pulaski Highway	ion, give street and number)		4b. City, Town, or Location of Deal Havre De Grace	th .	4c. County of Dea Harford	th ·
		_	. Social Security Number	6. Sex 7. Age (In yrs. Ia	ist birthday)	If Under 1 Year If Under 24H	rs. 8. Date of Birth(irthplace (State or
	Funeral Director		218-44-6371	1X M 2 F 60	Yrs	Months Days Hours Mi	n. 02 12	2 47 Fore	country) MD
			Usual Residence of Decedent				- 1	M VI	10d. Inside City Limits
· Mayer	any	1	10a. State 10b. Count	'	Town or Local	avre De Grace			1 Yes 2 X No
	f shov	١ق		Harford	- 11	10f. Zip Code		Citizen of What Co	ountry?
	r 28a-	Director	10e. Street and Number	3mt 1D		21078	8 H	U.S.A	
	ith the		/OO Pulask	i Hgwy Apt 1B	S. 13. W	as Decedent of Hispanic Origin? (Specify Yes or No-		erican Indian, Black,
	y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. teath and Mental Hygiene. tent 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.			Married Armed Forces? Yes 2 No		Yes, specify Cuban, Mexican, Puer	no Rican, etc.)		
	after d			Divorced If Yes, Give Year or Dates:	_	Yes 2 X No specify: nt's Usual Occupation (Give kind o	of work done 1	Specify: B] 6b. Kind of Busines	
	hours after "natural",	Completed by	15. Decedent's Education (S Elementary/Secondary (0-1	pecify only highest grade completed) 2) College (1-4 or 5+)	during r	nost of working life. DO NOT use a	retired)	n gozganian sloter di servici anni e servici di se	and and all the training to
	5-0036 led within 72 tygiene. other than '	ag .	12th grade	na	Lon	g Shoreman			Railroad
	215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	히	17. Father's Name (First, Midd	ile, Last)			me (First, Middle, Ma		
4 4	121; libe fil ental h arrked	Be	Fulton Warn 19a. Informant's Name/Relation	er Ewell	19b. Mailii	Jennie ng Address (Street and Number of	Mabrey or Rural Route Numb	er, City or Town, St	ate, Zip Code)
	MD 21 d 2 should: lith and Mey n 27 is man numatic ev	-	Dorethea Ew			Manorview Ro	pad, Bali	timore,	Md 21229
	and 2 and 2 Health item 2		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of cemetery,	Date	20c. Location - City	or Town, State
	nordages lant of late if other		1 X Burial 2 Crema 4 Donation 5 Other	tion 3 Removal from State	rison	Forest Vet	7/14/07	Owings	Mills, Md
4 160	Baltimore, MD 21215-003 permit; Pages 1 and 2 should; be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Serv	ice Licensee	22.	Name and Address of Facility	,		
-61			Sala I	, or a lications that caused the death	n. Do not enter	the mode of dying, such as cardia	ec or respiratory arres	more, Most, shock, or heart	Approximate Interval
	Physician Medical		failure. List only one cau	use on each line.		IC CARDIOVASCULA			Between Onset and Death
	∴xaminer		Immediate Cause (Final dise or condition resulting in death			TO OHRDIOTHEODEL		1	
		Ш	Sequentially list conditions,	b	ot).	2			
		in in in	if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate	use C.		PHY LEGIC TO			
V	ed ssit	Examiner	events resulting in death) La	ast Due to (or as a consequence	of):				
•	3760, ficate be executed g physician and s the burial - transit		UNPENDED	d					
	8760, tificate be an physicia as the buria	Med	IF FEMALE:	23c. If yes, outcome of pre	egnancy			23d. Date of del	livery Day Year
	leath certificate attending p	1 75	23b. Was decedent pregnant past 12 months?	in the 1 Live birth 4 Pregnant at time of c	J	Fetal death 3 Ectopic pro Other (Specify)	egnancy	MOILLI	Day 700.
	Box 68 e death cert the attendir ed for use a	ysic	1 Yes 2 No 9	Unknown g Unknown					to the course of death?
	that the denoted by the		Part II. Other significant co	onditions contributing to death but not	t resulting in th	e underlying cause given in Part I.			te to the cause of death? Probably 4 Unknown
	ires that to signed by d be detac		M					an 24b. We	re autopsy findings available
	cords, law require has been si	Completed					autop perfor	sy price rmed? dea	
	Reconstant The la cate has page 2	E	1			CO Plane of Death (Ch	1 Yes	2 No 1	Yes 2 No
	tal Rection: The certificate ector, page	Be	25. Was case referred to me examiner?	Hospital: 1 Inpatient 2	ER/Outpati	26.Place of Death (Chent 3 DOA Other: 1		Residence 6	Other: Scene
	Division of Vital Records, piral or Attending Physician: The law require ours after death. Leval Director: After this certificate has been si filled in by the funeral director, page 2 should b	은	1 ✓ Yes 2 No 27. Manner of Death		28b. Time		28d. Describe	how injury occurred	
	nding rth.	ļ ii	XX Natural 5	Pending		1 Yes 2 N			
	/iSiC or Atte her dez virecto	fical	2 Accident 3 Suicide 6	Investigation Could not be 28e. Place of Injury - Al	t home, farm, s	street, factory, office building, etc.	28f. Location (S or Town, S	Street and Number State)	or Rural Route Number, City
	Divisior ospital or Attend hours after death nneral Director:	Certification:	4 Homicide	determined (Specify)			and due to the caus	ea(s) and manner a	s stated
	Hos 24 h Fur felv		29a. Certifier (Check only one) Certifyii	ng Physician: To the best of my knowl I Examiner:On the basis of examination	edge, death o n and/or inves	ccurred at the time, date and place tigation, in my opinion, death occu	rred at the time, date	and place, and due	e to the cause(s)
4	To the within To the comple	Medical	29b. Signature and title of c	and manner stated.		29c. License number		29d. Date signed	(Month, Day, Year)
		-	Li	hi, not		O.C.M.E.		September 5	5, 2007
	100		30. Name and address of po	erson who completed cause of death (It	tem 23a)		4		
1	10		Ling Li, MD, Ass	sistant Medical Examiner 1	11 Penn S	treet, Baltimore, MD 2120	1 		
_		State	31. Date filed (Month, Day,	Year) 32. Registrar's Sign	nature	100			

aoheed Gazal		State of Maryland / Department of 1- For State Certificate of Registrar		ygiene Reg. N	2007 293	356
Physicia ledical Exami		Decedent's Name (First, Middle,Last) Taoheed Gazal	W ,	Date of Death Month Da September 6	3. Time of Death 2007 0327 hrs	
4. X .		4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center	4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
Funeral Director		5. Social Security Number 212–57–8829 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min.		MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Nigeri	ia
faryland 28a-f show any at once.	tor	Usual Residence of Decedent 10a. State	Bowie		10d. inside City Lin 1 X Yes 2	
the Mary a or 28a- tiffed at	Director	10e. Street and Number 16415 Elkhorn Lane	10f. Zip Code 20716	10g.	Citizen of What Country? USA	
after death with the Maryland al", or items 23a or 28a-f she iner must be notified at once	by Funeral		as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 XX No specify:		14. Race - American Indian, Black, White, etc. Specify: Black	-
36 in 72 hours han "natur lical Exam	Completed b	Flementary/Secondary (0.12) College (1.4 or 5+)	nt's Usual Occupation (Give kind of v nost of working life. DO NOT use reti ldier		US Army	-18
ID 21215-0036 should be filed within 72 and Mejrial Hygiene. 7 is may kee other than in a fice event, the Medical	Be	17. Father's Name (First, Middle, Last) Ligali Abiola Gazal	Augus	(First, Middle, Maid ta Oligo		
MD 21 nd 2 should alth and Me mi 27 is ma	٩	Risikat G. Gazal / Step Mother 16415				
E E E E		1 X Burial 2 Cremation 3 Removal from State Cheffennan			Cheltenham, Maryla	ınd
		21. Seature of Funeral Service Licensee Victor P. Doda 22. 15. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the disease.	Name and Address of Facility Darles L. Stevens 501 East Fort Ave	nue. Bait	imore Maryland 212	230
Physician /Medical *xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Authorized Gunshot Wounds Due to (or as a consequence of):	the mode of dying, such as cardiac o	respiratory arrest,	Between Onset a Death	
ecuted and - transit	Examiner	Sequentially-list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Lue to (or as a consequence of): C. Due to (or as a consequence of): d.	. (1) (1) (1) (1) (1) (1) (1) (1) (1)			
§ ≝ ≃ [Medical	UNPENDED X AMENDED #6, perFH, G871, 9/13	/07,WS			
lox 6876 leath certificat e attending ph	sician/	22c. If yes, outcome or pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fee	etal death 3 Ectopic pregna ther (Specify)		23d. Date of delivery Month Day Year	
, P.O. E res that the d signed by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?	
of Vital Records, g Physician: The law requir this certificate has been some of the continue o	Completed			24a. Was an autopsy performe		of of
1 of Vital Recing Physician: The After this certificate funeral director, page	To Be C	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatien	26.Place of Death (Check t 3 DOA Other Mursin	only one) g Home 5 Res	sidence 6 Other:	
sion of ttending Pl death. etor: After y the funera		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Manth, Dex Year) Sep 6, 2007 28b. Time of 0245 hrs	Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how Subject shot	injury occurred	
Division sepital or Attendii hours after death.	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street		or Town, State 98th Avenue & La	et and Number or Rural Route Number, (e) anham Severn Road, Lanham, MD	
D To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the bast of my knowledge, death occurrence) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ation, in my opinion, death occurred a	at the time, date and	place, and due to the cause(s)	
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		3d. Date signed <i>(Month, Day, Year)</i> September 6, 2007	
27		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn \$	Street, Baltimore, MD 2120	1		
St Regist	ate		. J. J			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Day 07 Physician 09 2007 2305 ARTHUR GOLDEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 214-36-7008 69 June 23, 1938 West Virginia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Director **Allegany** Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12315 Wildcat Hollow Road SE 21502 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be

Edgar James Golden Julia E. Henderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ruth Golden/spouse 12315 Wildcat Hollow Road SE Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Ronal d State Anatomy Board 655 W. Baltimore Street Licensee S. Wade? Baltimore, MD

Physician /Medical Examiner

Department of Health ar Important: If Item 27 is any Injury or other trau

nding physician and use as the burial-transi nse atten for u signed by the a d be detached f page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

	23a. Part1. Inter the disease, if comboshock, in heart failure. Lot only of	ic in his first caused the deat one cause on each line.	h. Do not enter the m	ode of dying, such as cardia	ac or respiratory arrest,	Approx Interva	imate Il Between and Death			
	Immediate Cause (Final disease or condition resulting in death)	a. COPOLAR Due to (or as a conseq		ery Dis	CASC	, T	12S			
ner	Sequentially list conditions, any backing to immediate cause. Enter Underlying	b Due to (or as a conseq	Due to (or as a consequence of):							
Il Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq	Due to (or as a consequence of):							
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1	al death 3□Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day	Year			
d by Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tobaccc	use contribute to the caus	e of death?			
Sompleto					24a. Was an autopsy performed?		n of cause of			
To Be (25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	 Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3□	Othor	eath (Check only one) Home 5 Residence	6 □Other (Specify)				
tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred				
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. Speci	ome, farm, street, factify)	tory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route tte)	Number,			
dical (29a. Certifier 1 ☐ Certifing Ph (Check only one) 2 ☐ Medic Exam	ysician: To the best my known miner: On the basis of examination and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and plation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as stated. and place, and due to the ca	use(s)			

21502

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

, Cumberland, MD 21502

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) SEP 1

CONCIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D36766

Registrar

SEP 1 3

2007

State of Maryland / Department of Health and Mental Hygiens, Beg. No. 2007 29359 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9/10/078:00 a м Gerarda Gensler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner Baltimore Manor Care Nursing Home Rosedale Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F 85 Yrs. 218-09-7722 Director Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County r than "natural", or itame 23s or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore Essex MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8620 Kelso Dr. Apt D 415 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White Specify: þ 3 □Widowed 4 □Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Assembler Broom Factory other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in nent of Health and Mental in it is m 27 is marked o Mary A. Schneider John Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2502 Lolos Dr Kingsville, MD 21087 Karen Helmick-Niece/POA or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Zua. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Sacred Heart of Jesus 9/14/07 Baltimore, Maryland 5 Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. Baltimore, MD 21224 6224 Eastern Ave 23a Part1, Exter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, o hear failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 98 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions commonling to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Inknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 1 Tyes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 wursing Home 5 Residence 6 Other (Specify) é No Hospital: 1 🗌 Yes 3 DOA Certification: To 1 Inpatient 2 FR/Outpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 1 Deatural 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not Director: 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours e To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeflure and title of certifier who completed cause of death (Item 23a) (Type, Print) PACITO (Zi Ci 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar (Mark)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 166 HARROD SA 2007 /Medical 4a. Facility Name (If not institution, give street and nymber) 4c. County of Death 4b. City, Town, or Location of Death Examiner NIP BALTINGRE If Under 1 Year If Under 24 Hrs.

Hours Min. Birthplace (State or Foreign
 Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 220 Months Director WASHING for, Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a State If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at BALTMUR 1 kes 2 No Director MAYY LAW 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U5A 4406 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status l □Yes 22 No f Yes, Give ∕ear or Dates: 1 Never Married 2☐ Married 1 ☐ Yes 25 Alo Baltimore, Maryland 21215-0036 Specify. þ Specify: 3 Widowed lack Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 16 mcmsker 12th grade Pages 1 and 2 should be filed nent of Health and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ke dGERS 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury common to the second s Bolhasa SHAWN Md 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 □ Donation 5 DOther (Specify) Effek Bloc ANBUTUS ArBUTUS, 22. Name and Address of Facility CHATOLING - Normal Signature of Funeral Service Licenses BALTINOCE airo 5240 REISTERSHUN Rd 23a. Part1. Filter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death In rediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ulmonay if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit ulmonai and Due to (or as a consequence of) attending physician Physician/Medical the as for use IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. the 9☐Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ò 2 □ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 certificate ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only of 1 ☐ Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cerlifie ted cause of death (Item 23a) (Type, Print) 30. Name and a

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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2007

2. Registrar's Signature

			1 - For State Registrar Amend Item	State of Maryland 8 per fh, g878	d / Depa 8 ,04/0	rtment of H	lealth and N Death	Mental Hygid	en 2007	29361
	Physic	an	Decedent's Name (First, Middle, Last					2. Date of Death Month	_Day Yea	3. Time of Death
4	/Medi	cal	4a. Facility Name (If not institution, give	MAE HAO	6 AN			SEPT	Pay 2007	12-50PM
	Examir	ner	Multi Medica				Location of Death		4c. County of De Boulti	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth	9. 5	Birthplace (State or Foreign
	Director		215 · 28 · 4007 1L Usual Residence of Decedent	DM 2 MF 74	Yrs.	World S Days	Tiodis Will.	05/17/193	33° /V	laryland
	yland now		10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits
	e Mar Se-1 sh Liffied	ctor	MD Carroll	County W	estmi	nster				1 □ Yes 2 No
	with th	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What	Country?
	leath i	Funeral	551 Sunshine 11. Marital Status	12. Was Decedent Ever in U.S	S 13 W	/as Decedent of Hi	157	acity Vas or No-	U.5.1	merican Indian,
9	or Iten	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give	If		spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	Black, Wi	
003	72 hours after death with the Maryland naturel', or Items 23a or 28e-1 show likel Exar, arrivel by Italied at	d by	3 Widowed 4 □ Divorced	Year or Dates:		☐ Yes 2 No	Specify:		Specify:	lack
21215-0036	d within 72 hours after death with the Marylan jene. Ir than "naturel", or Items 23a or 28e-1 show The Medical Exac is etcritaal be confilled at	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give k	ent's Usual Occupa rind of work done o O NOT use retired.	turing most of work	ing 16	b. Kind of Busines	ss/Industry
212	d within giene. er then "	Com	Elementary/Secondary (0-12)	Vears		el Worth		5	T. OF Y	MD
pu	be filed ntal Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	iden Sumame)	
Maryland	should b nd Menta marked matic e	မ	James Small c		10h Mailine	Address (Street		ne Shar		rall wood
Z	ilth ar 11th ar 27 is r treu	1	hobert Hagans	Son						
ore,	of Health of Health litem 27		20a. Method of Disposition		ace of Dispos	ition (Name of atory or other place	9)	Date 20	c. Location - City	0 21157 or Town, State
im	Pages ment of ent: If it		1 ☐ Burial 2 Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	en mou	nt	09.1	5.2007 B	altimor	e.mo
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licens	9	22.	Name and Addres	s of Facility You	ughac. G	ireen fu	new Service
	40200		23a. Part 1. Enter the disease, or compl	ications that caused the death	Do not enter	128 Libe	rry Rd	"handa	ustoun	MD 21133 Approximate
	Pnysician		Immediate Cause (Final	ne cause on each line.		. the made of dying	g, 500% a5 oaraido (or respiratory arrest	1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence	ence of):					dars
	Examiner	<u>.</u>	Sequentially list conditions,	DEMEN						year
7.	nsit	nine	rt any, leading to immediate cause. Enter Underlying	Due to (or as a consequent						
7	execu in and ial-tra	Examine	that initiated events resulting in death) Last	Due to (or as a conseque						years
8760,	cate be executed physician and : the burial-transit	dicai		l						
	sertific ding pl	0	IF FEMALE:	3c. If yes, outcome of pregnan						
Вох	leath certifi attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3 □E	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
<u>о</u> .	that the de led by the a detached f	hys	9 Unknown	9□ Unknown		,,				
S,	es ped	by	Part II. Other significant conditions con	tributing to death but not resul	ting in the und	derlying cause give	n in Part I.			to the cause of death?
orc	w requir been s should	eted							2 No 3 F	Probably 4 Winknown
Vital Records,	The law ate has page 2 a	Completed						24a. Was an autopsy performed	prior to	autopsy findings available completion of cause of
		Be Cc	25. Was case referred to medical				26 Place of Death	1 Yes 2.	1 ☐ Ye	s 2 No
	Physicien: this certific al director,	10 B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3 □ DOA Othe		ne 5 ☐ Residenc	e 6 □Other (Sp	ecify)
Division of	Attending Physicien: r death. sctor: After this certific. by the funeral director,	ion:	27. Mann of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how	injury occurred	
/isid	or Attencafter death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom	ne, farm, stree		es 2 No	28f. Location (Stree	t and Number or F	Rural Route Number,
2	al or A s after al Direct ad in by	Serti	4 Homicide	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	, idaisty, silies		City or Town, S	itate)	isla. Flosto (Valliper,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical (29a. Certifier Certifying Phys	ician: To the best of my knowner: On the basis of examination	ledge, death o	occurred at the time	e, date and place, a	and due to the caus	e(s) and manner a	as stated.
	thin 24 thin 24 the F mplete	Medi	one) 29b. Signature and title of certifier	and manner stated.		29c. License				
	S 7 8 7		9	DLE MA					Date signed (Mor	
	_	-	30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type, Pr	int)	7 7,50	36	17 /0	60101
	h		SHAKUN MA	LA GUPTA	9650	sant	10f0	old Suc	Ce 11	0 2/042
*	Sta Registra		31. Date filed (Month, Day, Year) SFP 1 3 2007	92. Registrar's Signatu	mark	* 0				

07-06560 James William H	ehe		oe or Print i						egible.		
values villani i		1- For State	ate of Maryi		tificate of D		a montan m		Reg. No.	200	7 2936
Physicia		Registrar 1. Decedent's Name (First, Midd	le,Last)					2. Date of De	eath Y	ear	3. Time of Death
Medical Examir		James William				St. Tour	Least as of Dooth	August 2	24, 2007 4c. Count		1150 hrs
(4a. Facility Name (if not institution Rear, Even Side 1200				altimore	Location of Death		4c. Count	y or Death	A 82
Funeral		5. Social Security Numbernals		7. Age (In yrs. Ia	st birthday) If	Under 1 Year	r If Under 24Hrs	. 8. Date of I	Birth (MM/DD/YY)		
Director		220-94-2862	1XM 2 F		27 Yrs.	nonths Days	s Hours Min	Jan 1	11, 1980	Foreigr Cou	ntry) MD.
		Usual Residence of Decedent									do u la circa Circa Licente
w any		10a. State 10b. County MD Anne	Arunde1	10c. City,	Town or Location	ımın i o					10d. Inside City Limits 1 Yes 2 X No
·land	Ē		Arunder		Glen B	f. Zip Code			10g, Citizen of V	Mhat Coun	
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 345 Gatewater	Court #2	04			21060		_	SA	
vith th		11. Marital Status	nk 12. Was De	cedent Ever in U.S			spanic Origin? (Sp				an Indian, Black,
leath v	Funeral	1 X Never Married 2 M	larried Armed F	orces?	If Yes,	specify Cubar	n, Mexican, Puerto	Rican, etc.)	W	ite, etc.	
after c	by F		vorced If Yes, Give Ye			s 2X No			Specify		ite
hours	ed k	15. Decedent's Education (Spe			16a. Decedent's U	Jsual Occupat of working life	tion (Give kind of v . DO NOT use reti	work done (;] red)	16b. Kind of	Business/Ir	ndustry unk
36 iin 72 iin 44 fran "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) 0	Casual	Labore	r		Var	ious	
d with	Com	17. Father's Name (First, Middle			-	unk	18.Mother's Name	(First, Middle	e, Maiden Surnar	ne)	-unk
215 be file mtal H- rked c	Be	Neil Thomas H						ela Jo			
e, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-fahe transmatic event, the Medical Examiner must be notified at once	္	19a. Informant's Name/Relations	ship (Type, Print)	father meh l	19b. Mailing Ad 	Mt. Ho	et and Number or l	Rural Route N Stree	lumber, City or T	21,154	Zip Code)
and 2 ealth 8 tem 27 traum		20a. Method of Disposition		20b. F	Place of Disposition	(Name of ce	cee bar	Date	20c. Locatio		
2 1 2 2 2 2 3 3 4 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		1 X Burial 2 Cremation	n 3 Removal	Jai	rematory or other rettsvil	olace) 1e Cen	ı. 9-	20-07	Jarre	ttsvi	11e, Md.
Baltimo permit Page Department of Important: injury or out		4 Donation 5 X Ott) er S	pooify: in 64	ato _	22. Nam	erandrAddres	s of Facility on	Rmera	1 Home	P.A.	P.O. Box
Balti permit Departin Imports injury o		konald	11111	rector	Polt	imoro	MD 2120	11 Tarr	ottevil	lo M	d 21084
Physician		23a. Part I. Enter the disease, or	r complications that	caused the death.	Do not enter the n	node of dying,	, such as cardiac o	or respiratory	arrest, shock, or	neart	Approximate Interval Between Onset and
Medical xaminer		Imm te Cause (Final disease	e a		NTOXICAT	ION AN	D COCAIN	E USE			Death
,		or condition resulting in death)	Due to (or as	a consequence of):						
	er	Sequentially list conditions, if any, leading to immediate		a consequence of	·):						
	mir	cause. Enter Underlying Cause (Disease or injury that initiated	C	a consequence of	J.						
cuted and transit	Ä	events resulting in death) Last	d	a b b b c c c c c c c c c c							
e execuian anian anial - tr	sician/Medical	UNPENDED	X #MENDED	#28e_perM nME,g871,	5,8872 ₇ 10/	3'.9.H	,12,15-2	20c, 22	1 9-25-1 per fh	0/ v t	
Box 68760, e death certificate be exent the attending physician ed for use as the burial.	Mec	IF FEMALE:	23c. If yes	, outcome of pregr	nancy				23d. Date	of delivery	
687 certifi nding se as t	ian/	23b. Was decedent pregnant in t past 12 months?	I LIVE	birth nant at time of de	2 Fetal ath 5 Other	death 3 (Specify)	Ectopic pregn	ancy	Month		Day Year
30x death te atter I for u	ysic	1 Yes 2 No 9 Ur	tue euro	nown	5 Other	(Specify)					
O. E at the d by the reached	y Phy	Part II. Other significant condi	tions contributing	to death but not re	esulting in the unde	erlying cause	given in Part I.			_	the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by I led in by the funeral director, page 2 should be detach	d by										ably 4 Unknown
cords, law requir thas been s	olete	·							itopsy		topsy findings available completion of cause of
Reco	Completed								erformed? es 2 No	1 V Ye	es 2 No
ian: ian: certific	Be	25. Was case referred to medic examiner?					e of Death (Check				
F VIC	101	1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient 3 28b. Time of Injur		Other4 Nursi	ng Home 5	Residence 6		Scene
n o iding l i. Afte	on:	27. Manner of Death 1 Natural 5 Per	dina	e of Injury th, Day,Year)	found at		Yes 2XX No		UNKNOWN		
Sio	icati	2 Accident Inve	action LOUIN	1 8-24-07 ace_of Injury - At ho	11:45 AM me, farm, street, f vacant lot			28f. Locatio	n (Street and Nu	mber or Ru	ral Route Number, City
Div Ital or rs afte	Certification:		uld not be ermined (Specif)	Found on FOUND	vacant lot IN AUTC			1200 B	n, State) lk. Glynd o	n St.	Balto, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier	hysician: To the be	est of my knowled	ge, death occurred	at the time, d	late and place, an	d due to the c	ause(s) and man	ner as stat	ed.
To the within To the comple	Medical		aminer On the basis	s of examination a stated.	nd/or investigation			at the time, d			nth, Day, Year)
	Σ	29b. Signature and title oncertifi	igr //			29c. Licens	.M.E.		August 2		
		//			000)	J				.,	
OCM	5	30. Name and address of perso Mary G. Rippie MD.	n who completed ca Deputy Chief			enn Stree	t, Baltimore, I	MD 21201			
St	ate	31. Date filed (Monto Day Year		Registrar's Signatu							
Regist			2001	C. S. C. S. S. S. S. S. S. S. S. S. S. S. S. S.	ire de la company	Mary Constant					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 1- State Registrar Amend 17, perFD, g871, 9.13.07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** Marjorie D. Harbstreet Sept 2007 12:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 M 2 F Director 261-32-9736 81 11 1925 FLDec. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f shov must be notified at Director MD Baltimore Glen Arm 1 ☐ Yes 2 🔽 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11630 Glen Arm Rd. L-11 21057 death v USA Funeral "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No þ Specify: white 3 Widowed 4 □ Divorced Completed er than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 7 is marked other traumatic event, \$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rembert Repibert Leman Vincent Roy Kooker Gertrude 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If Item 27 any Injury or other to The Rev. Mary Doyle Gaut/daughter 906 Kingston Rd., Balto., MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Richland Pres. Ch. Cem. 9/15/07 Greenville, SC Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) antery **Physician** Cormary UNS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 🗌 Yes 2**X** No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy 2 **W**No 1∐ Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) WOSP (C Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be exec Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: after death.

I Director: After this d in by the funeral di Filled 24 hours a To the Hosp within 24 hou To the Funer completely fill

Baltimore, Maryland 21215-0036

Registrar

DHMH 17 Rev 1/2001

State

Medical

29a. Certifier

AARON

29b. Signature and title of certifier

30. Nam and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST ROWSON MD Z1204 Uthrus, wo 32. Registrar's Signature 31. Date filed (Month, Day, Year)

and manner stated

1 Cruifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

58303

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** ROBERT CLAYTON HOY, SR. 1.15 PM 09 2007 12th /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CARROLL CARROLL HOSPITAL CENTER WESTMINSTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**√** M 2□ F 90 161-09-1758 3/22/1917 PENNSYLVANIA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 XYes 2 □ No CARROLL WESTMINSTER must be notified Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 21157 USA 37 WEST GREEN ST. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 ō Specify: WHITE þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE SALES INSURANCE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERMIE HANN JOSEPH C. HOY, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other tra CATHERINE E. HOY - WIFE 37 W. GREEN ST., WESTMINSTER, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State ST. JOHN CEMETERY 9/15/07 WESTMINSTER, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Sunature of Funeral Service Licensee 0 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Abdyminal Aurhic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of Examiner be executed resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Division or Vital 25. Was case referred to medical examiner? furieral director 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Ater ospital or Attending hours a er death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Cruifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 1 3 2007

~1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19, Ridge Road Westminister MD 21157 MAHMUSD 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

			For Amend Item 23a Item 21	ate of Maryland per dr., 887 per FH	1,00% Cer	rtment of H 13/0/dhb tificate of t	lealth and M Death	lental Hyg	iene _{sg. No.} 2007	29365
	Dhysisi		1. Decedent's Name (First, Middle, Last)		i	0-0-		Date of Death Month	n Day Year	3. Time of Death
	Physicia /Medic	_	Findre		P	101110		september	F005 + 79	1702 M
ja.	Examin	er	4a. Facility Name (If not institution, give stree			DIT	Location of Death	Lity	4c. County of Death	
Ī	Funeral Director		5. Social Security Number 6. Sex 216 - 62 - 253	7. Age (In yrs. la	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birth Co. , 1953 MAF	place (State or Foreign intry)
	D.		Usual Residence of Decedent					OCILIO	7 1 3 3 3 7 1 11 11	
	anylar show d at	_	10a. State 10b. County		Town or Lo					10d. Inside City Limits 1 □Xes 2 □ No
	Ba-f sotifie	ecto	MD. N/A	E	BALTI	7		14	Og. Citizen of What Cou	
	th with the 23a or 2 ust be n	Funeral Director	10e. Street and Number 427 N. GLOVER ST	•			224		USA	
980	be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married X Married	Vas Decedent Ever in U.S vrmed Forces? □Yes 2X No 'Yes, Give 'ear or Dates:		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2☐∰No	Ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: BI	, etc.
Maryland 21215-0036	within 72 ho ene. than "natur he Medical I	Completed		n npleted) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired MAN	during most of work	tina 1	16b. Kind of Business/I	ndustry
7	filed v Hygie ther int, th		17. Father's Name (First, Middle, Last)		OII.	F12.114	18. Mother's Nam	e (First, Middle, N	Maiden Surname)	
and		To Be	JABON WILSON				BETTY	NORRIS		
ary	2 should be and Menta Is marked aumatic ev	-	19a. Informant's Name/Relationship (Type. I	Print)	19b. Mailir	ng Address (Street	and Number or Rui	ral Route Number	City or Town, State, Z	ip Code)
	nd 2 alth a 27 Is r tra		RACHEL PAYTON (si	ster)	240	6 ASHLA	ND AVE.	BALTO	,MD. 2120)5
Baltimore,	0		20a. Method of Disposition 1 ☐ Buriał 2 ☑ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		metery, cier EEN M	sition (Name of natory or other place OUNT CR	EMATORY	17, 28	20c. Location - City or T 0.7 ALTIMORE ,	MD.
Balti	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licenses	Jourday	17	Name and Addre	ss of Facilin Car oh St B	alto. M	TITLU - MID - 2	neral Service,PA
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cannot be a carried to the carried to th	ons that opused the death	. Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	tard isoper	10	Show	∠_ Sepsi			Deatysd Death
7	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	C)!	Condi	ogenic S	ha ala	Days
£	No.	<u>.</u>	Sequentially list conditions b.	Due to (or as a consequ	ence of):	ZNOC				1 2009
K	page unsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	AMOXIC	Bau	0 ton	Neuro	genic Sh	ock	Day
(C)	e Bear	Exa	resulting in death) Last	Due to (or as a consequ	ence of):	3	1			100
8760,	cate be effectored physician and the burial-transit	dical	d	YEA AM	57.7				-	10 Days
9		Med	IF FEMALE:		-					
S. Box	requires that the death certific een signed by the attending p hould be detached for use as:	Physician/Me	23b. Was decedent pregnant in the past 12 months?	f yes, outcome pf pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	⊒Ectopic pregnancy ⊒Other <i>(specify)</i>	/		23d. Date of deli Month	very Day Year
P.0	that the died by the detached		Part II. Other significant conditions contribu	uting to death but not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
Vital Records,	signe d be	d by	il.			, , ,		1 □ Ye	es 2 No 3 Pro	obably 4 Unknown
COL		ompleted						24a. Was a	n 24b. Were au	topsy findings available
Re	The lav te has l age 2 s	Ę.						autops	y prior to o ned? death?	ompletion of cause of
tal		O	25. Was case referred to medical				26. Place of Dea	th (Check only on		2 □ No
<u>></u>	g :⊵ X	To Be	examiner? 1√Yes 2□ No Hosp	ital: 1 Inpatient 2 ☐ E	ER/Outpatier	nt 3 DOA Oth	or.		ence 6 Other (Spec	cify)
7 Or	ng Physter this neral di		27. Manner of Death 12 Natural 5 ☐ Pending	8a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor	ry at rk?	28d. Describe ho	ow injury occurred	
Sion	Attending r death. ector: After oy the fune	atio	2 Accident investigation				Yes 2 □ No			
Division	al or Att s after de al Direct ed in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined 2	 Place of injury - At hor building, etc. (Specify) 		reet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (n: To the best of my know On the basis of examinat and manner stated.						
	To the within To the comp	M	29b. Signature and title of certifier			29c. Licens	S- OC		9d. Date signed (Monti	n, Day, Year)
	8		30. Name and address of person who complete Jason . Shan	eted cause of death (Item	23a) (Type,		eet B	attimo	re Marylo	Ind 21287
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 3 200	32. Registrar's Signat	ture	and			1	
		_			44					

07-06993 Ryan Hakala

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			- For State Registrar		Certifica	te of D	Death		Re	g. No.	200	1 2936
Phys		n/	Decedent's Name (First, Middle,L						2. Date of Death Month	Day	Year	3. Time of Death
Medical Exa	amır		Ryan Edward 4a. Facility Name (if not institution,	Hakala		Ab	City Town or I	Location of Deat	September	8, 2007	nty of Death	1925 hrs
			Johns Hopkins Hospital	give street and number)			Baltimore	Location of Deat		40. 0001	ity of Death	
Fune	rai		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birth	day)	If Under 1 Year	If Under 24Hr	s. 8. Date of Birt	h (MM/DD/Y)		nplace (State or
Direct	tor		219-13-6648	XXM 2 F	36	Yrs.	Months Days	: Hours Mir	08/23	/1971	Foreign Cou	n Intry) Ohio
25,135 187,			Usual Residence of Decedent									
w any			10a. State 10b. County		0c. City, Town o	r Location						10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show	tonce	핡	MD Anne 10e. Street and Number	e Arundel		1.1	Sev Of. Zip Code	vern	110	g. Citizen of	What Coun	
e Mar	fied a	Director		- Davidson		l i		11//		g. Oldzell Ol		
5-0036 Substitute of the Maryland Algorithm of the Maryland Agent	must be notified at once.		450 University 11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was E		L 144 panic Origin? (S	specify Yes or No-	14. R	ace - Americ	oA can Indian, Black,
death	nust	Funeral	1 Never Married 2 X Marri	ied Armed Forces?	No	If Yes,	specify Cuban,	, Mexican, Puert	o Rican, etc.)	N	/hite, etc.	3 4 5
after a	ner 1	ğ.		ced If Yes, Give Year			es 2 X No			Speci		nite
hours	Ехаш	ed ed	15. Decedent's Education (Specify		d			ion (Give kind of DO NOT use re		16b. Kind of	f Business/Ir	ndustry
36 ain 72	the Medical Exa	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+	·	Rui 1 d	ing Eng	rinoor		Comm	orojol	Properties
5-00 led with tygien	pe W	녌	17. Father's Name (First, Middle, La			Daire			e (First, Middle, M			. Floperties
21215-0036 uld be filed within 7 Mental Hygiene.		Be	Edward Jack Hal					Judith	Beatric	e Clos	se	
	or other traumatic event,	2	19a. Informant's Name/Relationship		19b.		·		Rural Route Num			
ore, MD 2 es 1 and 2 shou of Health and 1	la la	-	Mrs. Eve Hakala 20a. Method of Disposition	ι / wife	20h Place of		Univers	sity Dri	ve, Se	vern,	Mary 1	and 21144
Ore ges l a of He	the life		1 Burial 2 XX Cremation	3 Removal from State	e cremato	ry or other	place)		14		1.0	
Baltimore, MD sermit. Pages I and 2 sho Department of Health and	y or o	1	4 Donation 5 Other Spec 21. Signature of Funeral Service Lic		Chesap		Cremati ne and Address		12/2007			
Balti permit. Departr	injury	ļ	21. Signature of Fulleral Service Ele	1	May 257			. 1	2nd Ave & Cremat	ion Se	Glen	Burnie, Mo s 21061
Physici	an	7	23a. Part Enter the disease, or co	mplications that caused th								Approximate Interval Between Onset and
/Medio xamir		4	Immediate Cause (Final disease	a. Dilated care	diomyopati	hy		A. Provider		4 . 4	* 1	Death
7.0		-1	or condition resulting in death)	Due to (or as a conseq	uence of):			, to	-/ -			
		힐	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):			ALP T				
		Examiner	cause. Enter University Cause (Disease or injury that initiated	C. Due to (or as a conseq	wence of:							
d uted	5 42 ■		events resulting in death) Last	d.	acrice or,							
760, icate be executed rulevician and	burial - t	/Medical	X UNPENDED	AMENDED ,27,p	erME 0871	9/15						
760, ficate be		Me.	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome	of pregnancy						e of delivery	
Box 68 death certif		Sian	past 12 months?	1 Live birth Pregnant at tir	me of death 5	_	death 3 ∟ ·(Spe <i>cify)</i>	Ectopic pregr	ancy	Mont	h D	ay Year
Boy death	ed for	Physician	1 Yes 2 No 9 Unkno	g Unknown		Other	(Opcony)			19		
P.O.	be detache	by P	Part II. Other significant condition	is contributing to death t	but not resulting	in the und	erlying cause g	iven in Part I.				the cause of death?
S, To	ld be	edt							1			ably 4 Unknown
cord	2 should	bet							24a. Was a autop: perfor	sy		topsy findings available ompletion of cause of
tal Rec tian: The l	page	Completed							1 ✔ Yes		1 ✓ Ye	s 2 No
ital ician:	ector	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient				of Death (Check		Danidana	C 011	
of V ing Phys	eral dir	앍	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury		ipatient 3		y at Work?	ing Home 5	Residence low injury oc		:
Division of Vital Records, rat or Attending Physician: The law require the refer the state from a precentificate has been as		틸	1 X Natural 5 Pending	(Month, Day,Yea	ar)			res 2 No				
ivisior or Attenc after death Director:		E	2 Accident Investig 3 Suicide 6 Could n	28e Place of Inju	ry - At home, far	m, street,	factory, office b	uilding, etc.			umber or Ru	ral Route Number, City
Dipital of ours at	filled	Certification:	4 Homicide determi						or Town, S	iate)		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certify within 24 hours and the death.	completely filled in by	- 1	Torroom only	sician: To the best of my l	_							
To th withiu	comp	Medical	29b. Signature and title of certifier	ner: On the basis of exami and manner stated.		vesugation	29c. License		ar me une, date i			e cause(s)
		=	200. Signature and title of certifler	1 m 11 0			O.C.N				ber 10, 2	
/		-	30. Name and address of person when	no completed cause of de	ath (Item 23a)		1 3.5			- 35.011		
K			Carol Allan MD Assis	stant Modical Evami		enn Str	eet, Baltimo	ore, MD 212	01			
	Sta	ate	31. Date filed (Month, Day, Year)	2007 32. Re (strar's	Signature	da	4					
Re	gist	ar	25, 7.9	2007	- 4	1	14700					

amend 25 per Dr. g871 9/13/07 KRH
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygien 2007

			1 - For State Registrar		State of Ma	aryland		artment of F rtificate of a			, ,	gierie Reg. No		2 3 3 0 1	
1			Decedent's Name (First, M.	iddle, Las	t)						2. Date of Dea Month			3. Time of Death	_
<	Physici /Medic		ALLEN	I	AHIC						70	03	100	1 1320 PM	1
	Examin		4a. Facility Name (If not institu	ıtion, give	street and number)	•		4b. City, Town, o	r Loca	tion of Death		1	. County of Dea		
			- 1	1 4 -	SOH 22		AL	SILVE		SPRI	NO	M	1012	OMERY	
ш	Funeral		5. Social Security Number	6. Se	7. Ag ZIM 2□F	e (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	Ho	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day	y, Yeer)	9. Bir	thplace (State or Foreign buntry)	n
	Director		none Usual Residence of Deceden	1		· · ·		6	<u> </u>		06,2	1, AL	OIMA	1891 CHW	7
	laryland show		10a. State 10b. Cou			10c. City, 7	Town or Lo	cation						10d. Inside City Limits	
	with the Marylan a or 28a-f show be publised at	io	MD MO	NTG	OMBRY	BRI	TS1	VILLE						1 Ves 2 No)
	or 28	lre	10e. Street and Number					10f. Zip Code		~ ~			tizen of What C	ountry?	
	death with the Maryland ms 23a or 28a-f show rmust be pulified at	Funeral Director	12079 (3812	SVILLE	RI	7	120	7 (05			ISA		
	ter dea Items	nu	11. Marital Status		12. Was Decedent Armed Forces?		13. \	Was Decedent of H f Yes, specify Cuba	lispani an, Me	ic Origin? (Spe exican, Puerto I	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whi	eńcan Indian, e, etc.	
36	hours after tural', or Ite al Evamina	by F	1 Never Married 2 ☐ 1 3 ☐ Widowed 4 ☐ Divor		1 ☐ Yes 2 ☑1 If Yes, Give Year or Dates:	NO		1 ☐ Yes 202 No	Spe	ecify:			Specify: W	HITE	
21215-0036	be filed within 72 hours after death watel Hygiene. d other then a natural; or Items 23s other then Medical Evant act must event. The Medical Evant act must	ted	15. Dece	dent's Ed	ucation		16a. Deced	dent's Usual Occup	ation			16b, K	(ind of Business	/Industry	
215	within 7 ene. than "n	Completed	(Specify only his Elementary/Secondary (0-1		College (1-4or 5	i+)	life. I	kind of work done DO NOT use retired	aunng d)	most of workii	ig				
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pu	tal Hydrau oth	Be	17. Father's Name (First, Mid								(First, Middle,			a	
Уlа	Men Marke Marke	²	ALMIR				40h M-111				LIE		AHI		
Maryland	12 st hand 7 Is n traun		19a. Informant's Name/Relat		ype, Print) S HOSPI	. [1]	_	ng Address (Street			,		R SPRIL		
	is 1 and 2 should of Health and Men item 27 Is marke other traumatic		20a. Method of Disposition	CO2	2 (1021)	20b. Plac	e of Dispo	sition (Name of			ate 31		ocation - City or		•
Baltimore,	Pages ment of ant: If it ury or c		1 ☐ Burial 2 ☐ Cremat `4 ☐ Donation 5 💆 Othe	on 3 🗆	Removal from State)in state	cem	netery, cren	natory or other plac	сө)						
Balt	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Sen	vice Licen	Pleasant	int	J St	Name and Addre ate Anato Altimore,	omy	Board	655 W.	Bal	timore	Street	
			23a. Part1. Enter the disease shock, or heart failure.	o, or comp		the death.					r respiratory ar	rest,		Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_	a MULT	IOR	GAR	J FAIL						Onset and Death	
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		ē	Sequentially list conditions, if any, leading to immediate	J	b. Due to (or as		. , , -	61.164	`						
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-	ertifica ling pl		IF FEMALE:		00- 16										
.O. Box	requires that the death certificate be execu een signed by the attending physician and hould be detached for use as the burial-tra	Physiclan/M	23b. Was decedent pregnand in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)	4				23d. Date of de Month	livery Day Year	
ο.	that ned by deta		Part II. Other significant con	ditions co	ontributing to death b	ut not resulti	ing in the u	nderlying cause giv	en in F	Part I.	23e. Did to	bacco	use contribute t	the cause of death?	
rds	quires n sigr	d b	DISSEMINA	CST	INTROVE	+SCUI	AR	COAGL	ال	OPATHS	1 10 Y	es 2	No 3□P	robably 4 Dunknown	n
000	- D G	Completed by	EXTREMEL	1 10	W BIRTH	WEI	CHT				24a. Was		24b. Were a	utopsy findings available completion of cause of	е
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ital		BeC	25. Was case referred to me- examiner?	dical					26. 1	Place of Death	(Check only o				
<u>_</u>	9 0 =	To	1 ☐ Yes 2½ No		Hospital: 1 Inpatie		7/Outpatien		41	-			6 ☐Other (Spe	ocify)	
n o	fter	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pe	nding	28a. Date of Inju (Month, Da	ry y Year) 28	8b. Time of Injury	Wor			28d. Describe h	now inju	iry occurred		
sio	Attending r death. ector: After by the fune	icat	3 ☐ Suicide 6 ☐ Co	estigation uld not be		uni Atham	o form etc	M 1 (105	2 🗆 No	28f Location (9	Street a	nd Number or F	ural Route Number,	_
Division of Vital Records,	after after Direct	Certification:	4 Homicide de	termined	building, et	c. (Specify)	o, iaiiii, sti	eet, factory, office			City or Tow	m, Stat	e)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C			ysician: To the best liner: On the basis o and manner st	f examination									
	To the within 2 To the comple	Me	29b. Signature and title of ce	rtifier				29c. Licens	se num	nber		29d. Da	ate signed (Mon	th, Dey, Year)	
			1610).m	E Jel	_ M	7	DL	2:	20h		07	02	2007	
			30. Name and address of per	son who	completed cause of c	leath (Item 2	3a) (Type,	Print)					· · · · · · · · ·		
			TRSSICA	D	MCADOO	MD	120	00 FORE	EST	GLEA	JRD 9	SILI	UER S	2H DUIST	7
	Sta Registi		31. Date filed (Month, Day, Y	ear) 3 20	32. Registr	ar's Signatur	ге	A PLANT							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 29368 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 10 2007 **Physician** JONES EDWARD 5:12 PM /Medical Facility Name (If not institution, or Location of Death 4c. County of Death City, Town, Examiner lfina Confer NIA 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Months Days Hours Min 215-46-6043 Director MARCH 24.1948 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural"; or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MARVLAND 10e. Street and Number 10g. Cirizen of What Country? 12 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 THGRADE 17. Father's Name (First, Middle, Last) Be ဂ္ WARD HOMAS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 shr Department of Health and Important: If item 27 is m any injury or other traum. MD. 21231 GIL LORI 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 4 Donation 5 ☐ Other (Specify) WOODLAWN, MARYLAND JR. FUNERAL HOME 22. Name and Address of Facility 21/Signature of Funeral Service ROWN BALTO, MD 21217 FULTON Part1. Enter the disease, or complications that caused the death. shock, or he art failure. List only one cause on each line. I we distance the cause of condition a.

Due to (or as a construction sulting in death) Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, nouswall cell long caucer **Physician** 6 mart /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner stag cheered disease The law requires that the death certificate be executed as the burial-transit Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. èq 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has I 1□ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 1 __Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) Intury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 🖊 🗖 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature

ant title of certifie

address of person wh

3

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

81.

301

32. Registrar's Signature

September 10,2007

Baltmar, ND 2120

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Η, Jones James 09 07 06:05 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bon Secours Hospital Baltimore If Unde Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months X M 2□ F Days Hours Min Director 89 216-10-1862 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Y□Yes 2□No Director Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or ? r must be n 21223 U.S.A. 2210 Penrose Ave Funeral ural", or items 2 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Y Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes ⊋☐ No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift Operator General Refractories 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fil of Health and Mental H Fitem 27 is marked oth r other traumatic even Be Eva Matthews James Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 i Dorothy Jones-Wife Penrose Ave, Baltimore, Md 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 □ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or 4 □Donation 5 □ Other (Specify) Garrison Forest Vet 9/17/07 Owings Mills, Md Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West
4300 Wabash Ave, Baltimore, Md
23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Immediate Cause (Final sease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any leading L. Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the ase 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day for in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 : perform director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2ER/Outpatient 3 □ DOA P 1 ☐ Yes 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 1 Waturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the thin 24 hours are o the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier .0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, SEP

State Registrar

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 29370 State of Maryland / Department of Health and Mental Hvoiene

			1- For State Control of Pleath and Wentan Certificate of Death		g. No.	
Ma	Physici dical Exam	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month	Day Year	3. Time of Death 1656 hrs
Ţ.	uicai Exaiii	illei	Michael Johnson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of D	September	9, 2007 4c. County of Deat	
			Johns Hopkins Bayview Medical Center Baltimore		N/A	S 1000
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 213.84.0937 1 Mm 2 F Yrs. Wonths Days Hours Usual Residence of Decedent	Min. 8. Date of Birth	(MM/DD/YYYY) 9. Bi Forei 2 196 Co	
	, any		10a. State 10b. County 10c. City, Town or Location	: 4		10d. Inside City Limits
	daryland 28a-f show 1 at once.	tor	MD N/A Baltimore			1 X Yes 2 No
٠	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once.	al Director	5205 Goodnow Road Apt. L 10f. Zip Code 21206	:	g. Citizen of What Cou	
	ter death wi	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 1 Yes 2 No specify:	? (Specify Yes or No- uerto Rican, etc.)	White, etc.	ack,
	ours aft atural' kamine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind		16b. Kind of Business	0.000
	5-0036 led within 72 ho Hygiene. other than "ns the Medical Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) And Car Detailer	e retired)	Fox Ch	evrolet
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	212 ould be 1 Ments s mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	r or Rurat Route m	ber, City or Town, Stat	e, Zip Code)
	e, MD 1 and 2 sho Health and item 27 is r traumati		Patricia Johnson/Wife 5205 Goodnow Ri			
	nore, ages 1 at nt of He nt: If ite other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City o	
	.= ~ ~ ~ ~		4 Bollation 5 Other Specify.	9 15 07	Baltin	ineral Swa
	Balti permit. Departr Import		Daupen C. 1 4905 York Roa	a Baltin	Tore MD 2	4212
	Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.	iac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
	xaminer		Immediate Cause (Final disease or condition resulting in death) a. Narcotic and ethanol intoxication Due to (or as a consequence of):	\$. 4		Death
		ایا	Sequentially list conditions, b			
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Colsease or injury that injury that injury that injury that injury that injury that injury that injury that injury th	."3		_
	nted d ansit	Exa	events resulting in death) Last Due to (or as a consequence of): d.			
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	3760, ificate be g physicist the buri	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live high	regnancy	23d. Date of deliver	y Day Year
	Box 687 death certific the attending p	sician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	egnancy	Worter	Day Teal
	that the death certificate by the attending detached for use as it	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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	ords, P.C. Iw requires that as been signed should be detailed.	Completed		24a. Was a		utopsy findings available completion of cause of
	Recc The fav	omo		perfor 1 ✓ Yes 2	med? death?	
	tal Fician: certifi rector,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other4 N			
	of Vig g Physi her this leral di	P.	1 ✓ Yes 2 No Impation 2 Extraordinary 28b. Time of Injury 28c. Injury at Work?		Residence 6 Other	er:
	ion (tending eath.	ation	1 Natural 5 Pending (Month, Day, Yeár) 2 Accident Investigation Fnd 9/9/2007 Fnd 4:25 pm 1 Yes 2 X No	unk		
	Division of Vital Records, ital or Attending Physician: The law require us after death. ral Director: After this certificate has been similed in by the funeral director, page 2 should b	Certification:	3 Suicide 4 Homicide 6 X Could not be determined (Specify) found at residence	28f. Location (S or Town, St Baltimore		ural Route Number, City
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, one)			
	F » F »	Me	29b. Signature and title of contifier 29c. License number		29d. Date signed (Me	
			0.C.M.E.		September 10,	2007
	OCME 34	OCV	30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore	e, MD 21201		
			31. Date filed (Month, Day, Year) 32. Resistrar's Signature			
	Regis	_	SEP 1 3 2007 Marie & Sich			
D	HMH 17 Rev 1/2	CUU:	ORIGINAL.			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11,2007 Month **Physician** Stanley Koczorowski Jr. September A^{M} 7:44 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 203 Robwood Road Dundalk If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) January 13, 1952 Birthplace (State or Foreign Country) **Funeral** 1XM 2□F Director 212-60-5206 55 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits notified at Director 1 ☐ Yes 2 No Maryland | Baltimore Dundalk · 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 203 Robwood Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or ite any finury or other traumatte event, the Medical Examines any injury or other traumatte event, the Medical Examines. ☐ Yes 2 XNo f Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No ģ If Yes, Give Year or Dates: Specify. Specify: White 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Ship Fitter Shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie J. Mawroski Stanley M. Koczorowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 8013 Charlesmont Road, Dundalk, Maryland Stacy Lintz 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory Baltimore City, MD. 4 Donation 5 Dother (Specify) 12, 2007 21. Signature of Juneral Service Licens Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Puril. Enter the disease, or complical his trat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, not k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Th mea disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the l IF FEMALE: signed by the attendin Id be detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 TYes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9-12-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21222 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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		For State Registrar				Ce	rtificate of	Death	1		2007	
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Examin	er			on, give street and num	iber)		4b. City, Town, o	r Location of Death	1			
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should be nd Mental marked o	ဥ		I GIBSC	-				HELEN			***	
S 60 60 10		19a. Informant's Na				_	ing Address (Street					Zip Code)
1 and Health Sm 27 ther tr		THERESA 20a. Method of Disp		R/DAUGHTER	20h		ERMINE CO	DURT EDG.	EWOOD,	_	21040 ecation - City or	Town State
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- Mag		23a. Fart1. Enter t	he disease, o	or complications that ca	used the dea						V, MD a	Approximate Interval Between
Physician /Medical Examiner	er	Immediate Cause disease or condition resulting in death) Sequentially list confirm to interest and leading to interest and le	(Final on on on on on on on on on on on on on	a. Due to (d	or as a conse	quence of):	-					Onset and Death
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could deterr	nined 20e. Place buildir	g, etc. (Spec	eify)	reet, factory, office		City or To	own, State)	ural Route Number,
the Hosp hin 24 hou the Fune npletely fi	Medical	29a. Certifier (Check only one)	2 ☐ Medica	ing Physician: To the I Examiner: On the ba and mann	sis of examir	nation and/or in	rvestigation, in my	opinion, death occu	rred at the time	e. date and	d place, and due	e to the cause(s)
To with	=	290. Signature and	1 MM	lum			D G	68303		Sep	tember	11 2007
6		30. Name and addr	ress of persor	and manner n who completed cause though in 22. Re 3 2007	of death (Ite	m 23a) (Type,	Charle	es St 18	won /	no	21204	
Sta Registr	te ar	31. Date filed (Mon	SEP 1	3 2007 32. Re	egytrár's Sigr	nature /	book					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11 2007 **Physician** SEPTEMBER **KRAUSS** 3:30A NANCY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON 8. Date of Birth 10/14/1953 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthdav) 6 Sex **Funeral** Months Days Hours 1 □ M 2 🕅 F Vrs MD 53 213-48-1061 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City. Town or Location 10a. State 10d. Inside City Limits Items 23a or 28a-f show ner must be notified at 1 □Yes 2 No REISTERSTOWN MD BALTIMORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 EMPIRE COURT 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or items 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SOCIAL WORK SOCIAL WORKER 7 Is marked other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BANK ROSENBAUM HARRIET KURT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 EMPIRE COURT, REISTERSTOWN, MD DONALD KRAUSS / HUSBAND 20b. Place of Disposition (Name of cemeters cremators or other place)

MEMORIAL PARK 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important; If It any Injury or o 1 X Burial 2 □ Cremation 3 □ Removal from State RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 09/12/2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Immediate Cause (Final Ancer **Physician** and disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2∐No 1∐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Efcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated the within To the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Batto ma 6701

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

			State of Maryland / Department of Health and	Mental H	ygiene	9		
			1- State Registrar Certificate of Death		Reg. No	2007	293	74
P	hysici	an	1. Decedent's Name (First, Middle, Last)	2. Date of I	Death Da	y Year	3. Time of I	Death
	/Medic		JOSEPH LEE	9	8	07	0100	M
	xamin	er	4a. Facility Name (If not institution, give street and number) / 4b. City, Town, or Location of Death	h	40.	County of Death	2	
E.	neral	-	5. Social Security Number 6. Sex/ 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		Birth	9. Birth	place (State or	Foreign
	ector	2	19 10 0471 12 N 2 F 82 Yrs. Months Days Hours Min.	MAY!	Day, Year)	_ Cou	mary)	10
pu	>		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		/		10d. Inside City	Limito
faryla	sho ed at	or	00. 1 01/2 02/2014				Yes	
the	28a-i notifi	rect	10e. Street and Number 10f. Zip Code		10a. Cit	izen of What Cou	ntrv?	
with	3a or st be	I Di	528 S. CATHERINE STREET 21223			512	_	
UU36 hours after death with the Maryland	"natural", or items 23a or 28a-f show	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S Ir Yes, specify Cuban, Mexican, Puer	Specify Yes or f	No-	14. Race - Ameri Black, White		
s after	or It	by Fu	1 Never Married 2 Married Wes 2 No	to moun, oton		Specify:	,	
5-0036 72 hours af	al Ex	q pe	15. Decedent's Education 16a. Decedent's Usual Occupation		16h K	ind of Business/Ir	LC/C	
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DG File	othe event,	Be (17. Father's Name (First, Middle, Last)	me (First, Midd	le, Maiden	Surname)		
yla ouid t	arker atic	2	WILLIAM E. LEC Myrt	16 6.	HX	126		
Mar 12 sh h and	raum traum		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rel To Dance Leafer Dancett See See Caffering	ural Route Nun		or Town, State, Zi	1	227
Healt	other t		20a. Method of Disposition 20a. Method of Disposition (Name of cemetery, crematory or other place)	Date /		ocation - City or T		
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Balti permit. E Departm	portant; / Injury ce.		21. Signature of Foheral Service Licensee 22. Name and Address of Facility		1x - x	Mari ton	est / far	É
a § 8.	any		Seed Nucles 5240 REISTENShin	Kd	Bal	Kpur ,	Rel 21	121
			23a. Part 1 Enter use disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or has it failure. List only one cause on each line.	c or respiratory	arrest,		Approximate Interval Betw	/een
Phys			Immediate Cause (Final disease or condition resulting in death) a. Reprivatory to the condition resulting in death)				Onset and D	eatn
	dical niner		Due to (or its a consequence of):	144.50				
200	500	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury bath bit bit and a sense or injury bath bit bit and a sense or injury bath bit and a sense or injury	-mo-c	up.		··-	
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death cer	for u	cian	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		1	23d. Date of delive Month		ear
j ê	ached	hysi	1 Yes 2 No 9 Unknown 9 Unknown	1				
The law requires that the	and det		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Die	d tobacco	use contribute to	the cause of de	eath?
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Or VII.al Physician: T	rector	Be	25. Was case referred to medical examiner? Hospital: Hospital: Processing the pr					
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VISION Attending	e fun	ation	1 DX Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No					
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To the Hospital or Attending Physician: The law within 24 hours after death.	omple	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Da	te signed (Month	, Day, Year)	
⊢ ≯ F	- 6		Madra N. Knan D6515	6		-8-0		
	(30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		l ,			
	5		DR NADRA KHAN	·				
	Sta	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
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			1- For State of Maryland / Department of Head State of Maryland / Department / De		ntal Hygieı Reg.	711111	29375
Ī	Physic /Medi		1. Decedent's Name (First, Middle, Last) OMETA F. LEE	2.	Date of Death Month	Day Year	3. Time of Death A
	Examin Funeral Director		5. Social Security Number 6. Sex () 7. Age (<i>In yrs. last birthday</i>) If Under 1 Year If Under 1 Y	MITC. If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Ye	4c. County of Death 9. Birthp ear) 9. County	lace (State or Foreign try) YLAND
	laryland show ed at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD N/A BALTIMORE CITY			1	0d. Inside City Limits 1 XYes 2 ☐ No
	with the N a or 28a-f be notifie	Direct	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Coun	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examine, must be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes ♀ ♀ No	1215 anic Origin? (Specif Mexican, Puerto Ric	y Yes or No- can, etc.)	USA 14. Race - Americ Black, White, Specify: BL	
21215-0036	within 72 hou iene. • than "natura th∗ Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done durilife. DO NOT use retired) EDUCATOR		16b	EDUCATI	,
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	1 and 2 s Health an iem 27 is u		STEPHANIE LEE / DAUGHTER 1008 RICHWO				- '
Baltimore,	Pages 1 and 2 nent of Health int: If Item 27 iny or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		: Location - City or To	
tim	Pa ner ant:		4 ☐ Donation 5 ☐ Other (Specify) MD NATL MEM PAR 21. Signature of Theraperal Service Licensee 22. Name and Address of the Company of the Co	of Capilla		AUREL, M	
8	Physician /Medical Examiner	ner	23a. Pand Effect the discusse, or complications that caused the death of one tenter the mode of dying, shock, or heart far ure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leauning to immediate cause. Enter Underlying Cause, (Disease or injury)	RTY HEIC	GHTS AV espiratory arrest,		
,0928	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C				
.O. Box 6	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as to	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □			23d. Date of delive	nry Day Year
rds, P.	w requires that been signed b should be dete	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given i	in Part I.	23e. Did tobacc	co use contribute to the	
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·Vital	Physician: this certificatal director, it	To Be	examiner? Hospital: Other:	6. Place of Death (C		e 6 □Other (Specify	<i>(</i>)
Division or	I or Attending after death. Director: After	Certification: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work?	t 28d s 2 □ No	Describe how in	njury occurred t and Number or Rura	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	nion, death occurred	d due to the cause at the time, date	e(s) and manner as si and place, and due to	ated. the cause(s)
)	To with	Σ	29b. Signature and title of certifier RES		Ì	Sept 12th	
	Sta	ate	21 Date filed (Month Day Year) 22 Polistrar's Signature	wore, 2401	W.Belve	der Ave 1.	, 2007 Baltonory 2121
	Registi	ar	SEP 1 3 2007				

LEE, OMETA.

_			1 - State Registrar		artment of Health and I	Mental Hygien	ZHH / / 43/D
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) JULIANN	C. L	YNDALL	2. Date of Death Month D SEPTEMBER	ay Year 6 45 PM
	Examin		4a. Facility Name (If not institution, give street and HARBOR HOSPI	TAL	4b. City, Town, or Location of Death BALTIMORE		c. County of Death
	Funeral Director		5. Social Security Number 217-50-9043 6. Sex 1 ☐ M 2 ☐ E	7. Age (In yrs. last birthday) 59 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea, May 10, 1	9. Birthplace (State or Foreign Country) 1948 Maryland
	Maryland	tor	10a. State 10b. County Maryland N/A	10c. City, Town or Lo			10d. Inside City Limits 1 X Yes 2 ☐ No
	with the	i Direc	10e. Street and Number 1121 West Lombard St.		10f. Zip Code 21223	10g. C	Citizen of What Country?
980	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or Iteme 23e or 28e-1 ehow event, I're Medical Exactle at must be indiffed at	by Funeral Director	1 Never Married 2 Married 1 7 Yes.	e 217 No	Mas Decedent of Hispanic Origin? (S I Yes, specify Cuban, Mexican, Puert I Pes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	(Give life.	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) LCAL Coder	king 16b.	Kind of Business/Industry Registered Nurse
/land 2		To Be C	17. Father's Name (First, Middle, Last) Michael Zahner		18. Mother's Nar Catheri	ne (First, Middle, Maide ne Helmick	en Sumame)
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		George Lyndall, husba	nd 196, Mailir	ng Address (Street and Number or Ru West Lombard St	ral Route Number, City Baltimor	re, MD. 21223
Baltimore,	Pages 1 and of He Int: If Item		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)		sition (Name of natory or other place) ide1 Crematory 0		Location - City or Town, State
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8760, <	Physician and whisician and the burial-transit	Jicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	at caused the death. Do not ent in each line. ULMONARY to (or as a consequence of): to (or as a consequence of): to (or as a consequence of):	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death OHOURS
P.O. Box 6	thet the death certificate led by the attending physic detached for use as the	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	quires that n signed b	by	Part II. Other significant conditions contributing to	odeath but not resulting in the u	, ,	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
of Vital Records,	The law requires thet the sete has been signed by the page 2 should be detache	Completed	RHEUMATOID AR	THRITIS	,	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
f Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) Hospital: 1	Inpatient 2 ER/Outpatier	Other	ath (Check only one)	6 ☐Other (Specify)
ion o	ding h. After fune		27, Manner of Death 28a, D	ate of Injury fonth, Day Year) 28b. Time o Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inj	jury occurred
Division	e Hospital or Attsm 24 hours efter deat Funerel Director: etely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home, farm, str uilding, etc. (Specify)	eet, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospital or Al within 24 hours efter of To the Funeral Direc completely filled in by	edicai	(Check only 2 Medical Examiner: On the	the best of my knowledge, deatle e basis of examination and/or in anner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause irred at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
)	To the within 2 To the complet	×	29b. Signature and title of certifier	SICIAN	29c. License number		Date signed (Month, Day, Year) TEMBER 9 2007
	3		30. Name and address of person who completed of DANA BEBU 3001 SOL	ause of death (Item 23a) (Type, ITH HANDVER	Print) STREET, BALT	IMORE, M	11 21225
	Sta Registi		31. Date filed (Month, Day, Year) 3:	2. Registrar's Signature	Contis		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 007 29377 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 2007 6 David B. Lester 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) St. Agnes Baltimore n/a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours Min. 1**⊠**M 2□ F 12/23/47 Virginia 59 577-62-9780 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Baltimore Baltimore Md 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21227 5724 Richardson Mews Square 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Motorola Radio Communications 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen B. Thatcher Harry Bowen Lester 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia L. Lester / Wife 5724 Richardson Mews Square Baltimore, Md. 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 9/10/07 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or companies shock, or heart failure. List only Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, MYOCAMPIAC Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

permit. Pages 1 and 2 to Department of Health and Important: If item 27 is me any injury or other **Physician** /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Director

Funeral

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Completed

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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Baltimore, Maryland 21215-0036

68760,

Box

P.O.

Records,

Vital

Hospital or Attending Physician: Division or

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be I

physician and the burial-transit cate has been signed by the page 2 should be detached certificate funeral Within 24 hours after ucc...

To the Funeral Director: Aft

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ysiciai i iyic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year
a Dy L	Part II. Other significant conditions of the Set Te	contributing to death but not resulting in the underly	ying cause given in Part I.		ouse contribute to the cause of death? 2 No 3 Probably 4 Unknown
on bien				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
) ט	25. Was case referred to medical		26. Place of Dea	th (Check only one)	
ם כ	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	ome 5 Residence	6 ☐Other (Specify)
- 110115	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	jury occurred
3	3 Suicide 6 Could not be determined		actory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, tte)
מונמו	29a. Certifier (Check only one) Certifying Ph	hysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investi- and manner stated.	curred at the time, date and place gation, in my opinion, death occu	e, and due to the cause urred at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
5	29b. Signature and title of certifier	(29c. License number	29d. D	Date signed (Month, Day, Year)
	Fredel	Klen m	036336	Se	prenser 6,2007
	30. Name and address of person who 344 7 Wilke	completed cause of death (Item 23a) (Type, Print	Beltimone	MO Z	

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** -01:56AM SEPTEMBER <u>Mary Aldona Lietuvnikas</u> /Medical 7005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Charlestown Care Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In vrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 F Days Yrs Director 85 10/25/21 217-18-5547 Lithunia Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Catonsville Md Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane BR 130 21228 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 NHo
If Yes, Give
Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, the once. 12 Nursing Administrator Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Andrew Lietuvnikas Brunis Hrengruke ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4303 Foxglove Court Belcamp, Maryland 21017 Geraldine R. Jackson / Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ■ Other (Specify Entombment Loudon Park Cemetery 9/14/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PULMONARY FIBROSIS MONTH S /Medical Due to (or as a consequence of): **Examiner** AMIODARDNE COBDUCINI LUNG INJURY TEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine CONGESTIVE HEART MONTHS and Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be Physician/Medical FIBRILL TEARO ATRIAL IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 1 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 22No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 Accident death 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a

To the Funeral I 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 9150 com mass Wittpmwani SEPTEMBER9, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

YASMIN AU

31. Date filed (Month, Day, Year)

SEP 1 3 2007

SUMBIUM MOTHS

BAUTIMORE

900

HAMIPANI, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 7

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Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate	complications that cause only one cause on each li	ed the death. line.						•	Approximate Interval Between
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DAYS Case referred to medical examiner. 25. Was case referred to medical examiner. 1						eath (Check only	one)		
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В	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month		3. Time of Death
	/Medic		HELEN MYERS			SEPTEMBI	ER 1 20	
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	Funeral		FREDERICK MEMORIAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birt)	nday) if Under 1 Year	If Under 24 Hr	8. Date of Birth	O Bi	rthplace (State or Foreign
	Director		219-14-9209 1□M 2∏F 83 Y	rs. Months Days	Hours Mir	Jan 18,	1924 Ma	ryLand
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
	Maryle f sho	tor	, , , , , , , , , , , , , , , , , , , ,	Isboro				1 □ Yes 2√ No
	r 28a	Director	10e. Street and Number	10f. Zip Code		1	10g. Citizen of What C	ountry?
	th with	al D	619 South Main Street		21798		USA	
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of F If Yes, specify Cub 	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	
36	rs afte	by F	1 ☐ Never Married 2 Married 1 ☐ Yes 2 Moon If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify:	white
9	2 hou latura Ical E	ted	15. Decedent's Education 16a.	Decedent's Usual Occup	pation		16b. Kind of Business	s/Industry
2	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done life. DO NOT use retire	dunng most of wo	orking		
7	Hygier Hygier Ther th		12 4 1 17. Father's Name (<i>First, Middle, Last</i>)	nomemaker	18 Mother's No	ıme (First, Middle,	own home	
Maryland 21215-0036	build be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show after event, the Medical Examiner must be notified at	o Be	Wilbur Samuel Gladhill			eatrice Z		
ary	should and Men marke	To	19a, Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street	and Number or F	Rural Route Numbe	r, City or Town, State,	Zip Code)
	and 2 ealth a n 27 is		Ralph-Myers/spouse 61	9 South Ma		t Woodsbo	ro, MD 21	798
altimore,	iter of Ho		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☒ Donation 5 □ Other (Specify)	Disposition (Name of crematory or other pla	ce)	Date	20c. Location - City o	r Town, State
Baltii	permit. Page Department Important: If any injury or once.		21. Signature of Euneral Service Sicensee ROHald S. Hade, Director	State Anat			Baltimore	Street
		_	23a. Pard. Enter the disease, or complications that caused the death. Do no	Baltimore, ot enter the mode of dying			rest,	Approximate
v	Physician		shock or heart failure. List only one cause on each line. Immediate Cabes (Final disease or condition	· emboli	<			Interval Between Onset and Death
*	/Medical		Immediate Cabse (Final disease or condition resulting in death) a. Due to (or as a consequence of the conditions)):	, ,			
	Examiner	_			disea	se		
	ted sit	nine	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying	f):				
	execu	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c	r):				
8760,	ficate be executed physician and is the burial-transit	dical	d					
မ	ertifica ing ph e as th	Med	IF FEMALE:					
8	leath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnanc	,		23d. Date of de Month	elivery Day Year
o.	ires that the de signed by the a I be detached t	ysic	1 □ Yes 2 □ No 4 □ Pregnant at time of death 9 □ Unknown	5 ☐ Other (specify) _				
ر. ص	s that ned by	by Pr	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
g	w requires been sig should be	ed b				1□Y	es 2□No 3□F	Probably 4 □Unknown
Records, P.O. Box	2 2 38	Completed				24a. Was a autops	sv prior to	autopsy findings available completion of cause of
Vita			25. Was case referred to medical		26 Place of De	1□ Yes eath (Check only or	2X No 1 ☐ Ye	
2	Physicia this cer al direct	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Oth	or.		ence 6 Other (Sp	ecify)
0	r Attending Phy er death. irector: After this i by the funeral o		27. Manner of Death 1	me of 28c. Injury Wor		1	ow injury occurred	
Sio	tendli leath. tor: A the fu	catic	2 Accident investigation		Yes 2 No			
Division or	l or Attendatter death Director:	Certification:	4 Homicide determined determined 28e. Place of injury - At home, fan building, etc. (Specify)	n, street, factory, office		28t. Location (S City or Tow	treet and Number or F n, State)	Rural Houte Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the ti	me, date and place	ce, and due to the courred at the time, or	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. Licens			29d. Date signed (Mor	
			And Thay no	Do	05506	> 1	Je ptember	, 2, 2007
			30. Name and address of person who completed cause of death (Item 23a) (1					
	Sta	te	Athrie J. Nagy, M.d., Frederick Memoria 31. Date filed (Month, Day, Year). 32. Agistrar's Signature					
ÿ	Registr		SEP 1 3 2007	GORAL S				

24a-29a, 30

07-06734 Charles McCaule

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 2938	2	22 (27)	0	7	2	9	3	8
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		I- For State		Certificat	e of Death		Red	ı. No.	101 2330
Physicia		Registrar 1. Decedent's Name (First, Middle,Las	t)				2. Date of Death		3. Time of Death
Medical Examin		Charles	William	Mo	Cauley		Month August 30,	Day Year 2007	0900 hrs
T.		4a. Facility Name (if not institution, give 822 Swift Road	e street and number)		4b. City, Town, Pasaden		Death	4c. County of Do	
Funeral		5. Social Security Number 6. Sec	ex 7. Age (li	n yrs. last birthd	ay) If Under 1 \	ear If Under	24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9.	. Birthplace (State or
Funeral Director		215-74-3639		49		ays Hours	Min. 07/31/	1958 Fo	Country) Maryland
2	ŀ	Usual Residence of Decedent 10a. State 10b. County	I10	c. City, Town or	Location	-			10d. Inside City Limits
ow any		,		Pasader					1 Yes 2 X No
Aaryland 28a-f show 1 at ouce.	ē	Maryland Anne A: 10e. Street and Number	runder	rasauei	10f. Zip Cod		140	g. Citizen of What (
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the M-dical Examiner must be notified at once	- 1	823 Swift Road			1 '	21122	10	U.S.A.	
h with	era	11. Marital Status 1 A Never Married 2 Married	12. Was Decedent Ev Armed Forces?	er in U.S. 1			in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A	merican Indian, Black,
er deat	Funeral		1 Yes 2 X	No	1 Yes 2 X				White
is after ural"	ā	15. Decedent's Education (Specify o	or Dates:	eted) 16a, De	cedent's Usual Occu		ind of work done	16b. Kind of Busine	
2 hou "nat	ted	Elementary/Secondary (0-12)	College (1-4 or 5+)	du	ring most of working				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the M dica	Completed	12	N/A		Cook		a se configura	Restaura	ant
5-0(sed will tygie of the Net	Ö	17. Father's Name (First, Middle, Last			_		s Name (First, Middle, M		
P Fill be fill printed irrked	Be	Joseph	Edward	McCa		Emma		rginia	Moyd
ore, MD 21215-0036 (set 1 and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than ther tranmatic event, the Midical	ို	19a. Informant's Name/Relationship (Patricia A. Hawl		196.1	Mailing Address (S 563 Seafor	treet and Num	ber or Rural Route Num t Pasadena,	ber, City or Town, S Maryland	State, Zip Code) 1 21122
Ce, Nealth		20a Method of Disposition			Disposition (Name of y or other place)	cemetery,	Date	20c. Location - Cit	y or Town, State
Baltimore, permit. Pages I at Department of He Important: If ite		1 A Burial 2 Cremation 3 4 Donation 5 Other Specify	Removal from State		aven Mem.	Pk.	09/05/2007	Glen Bu	rnie, Maryland
Baltimo permit. Page Department of Important: injury or ott	1	21. Signature of Funeral Service Lice			22. Name and Add	ress of Facility	ak Funoral	Home P	Δ
00 8 G E E	1. 7	Mg fl			3204 Moi	intain	ak Funeral Road Pasade	ena, Mary	Land 21122
Physician /Medical		23a. Fart I. Enter the disease, or comfailure. List only one cause on e	plications that caused the ach line.	e death. Do not e	enter the mode of dy	ng, such as ca	ardiac or respiratory arre	st, snock, or neart	Between Onset and
aminer	ì	Immediate Cause (Final disease a or condition resulting in death)			ication				Death
-	Н	b	Due to (or as a consequ	ience of):		**			
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):					
	Examiner	(Disease or injury that initiated	Due to (or as a consequ	ioneo of):					=
cuted und transit		events resulting in death) Last	•	ience or).					
ian a	//Medical		AMENDED #1, perME, G	871,9/26/0	07 TT / #23a	,PII,27,	28a-f, perME,g	g873, 11/9/0	O7 TT
760, ficate be g physic s the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy	Fetal death			23d. Date of de Month	livery Day Year
Box 687 Re death certific The attending perfect of the astending perf	sician	past 12 months?	1 Live birth 4 Pregnant at tin	ne of death 5	Other (Specify)	3Ectopic	pregnancy	Month	Day Teal
Box 68 cleath certil	ıysi	1 Yes 2 No 9 Unknow			Other (openly)				
P.O. s that the	/ Phys	Part II. Other significant conditions	contributing to death b	ut not resulting i	n the underlying cau	se given in Pa			te to the cause of death?
i, P.C ires that signed to the deta	d by	Seizure					1Yes	2 No 3	Probably 4 Unknown
OKECLE TO MLE of Vital Records, ng Physician: The law requir ufter this certificate has been s neral director, page 2 should	Completed						24a. Was autop		re autopsy findings available or to completion of cause of
ALT eco he law the has ge 2 sl	mc						perfor 1 ✓ Yes		ath? ✓ Yes 2 No
tal Recting The certificate		25. Was case referred to medical			26.P	lace of Death	(Check only one)		
Vita Vita hysteia	To Be	examiner?	Hospital: 1 Inpatient	2 ER/Out	patient 3 DOA	Other ₄	Nursing Home 5	Residence 6	Other: Scene
OUKE	7: T	27. Manner of Death	28a. Date of Injury (Month, Day,Yea	28b. Ti	me of Injury 28c.	Injury at Work	? 28d. Describe i	now injury occurred	
on the fu	tioi	1 Natural 5 Pending	End 8/20/2		9:30 am 1	Yes 2 X	No unk		
Division Division tal or Attendi	ifica	2 Accident Investiga 3 Suicide 6 X Could no	Discontinuity		m, street, factory, offi	ce building, et			or Rural Route Number, City
Pital Di	Certification:	4 Homicide determin		other—sce	ene		822 Swift	Rd. Pasad	ena, MD
Division of Vital Rec Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physic One) Certifying Physic Certifying Physic One)	cian: To the best of my ker:On the basis of exami	nowledge, deat	n occurred at the tim	e, date and pla	ace, and due to the caus	e(s) and manner as	stated.
To the within to the comp	Medical		and manner stated.			ense number			(Month, Day, Year)
	2	29b. Signature and title of certifier				.C.M.E.		August 31, 2	
		Calvill	1/1/	/		. U.IVI. L.		August 51, 2	
OT		30. Name and address of person who Zabiullah Ali, M.D. Ass	,		1 Penn Street, E	Saltimore !	MD 21201		
V			32. Registrar's						
St Regist	tate trar		2007	ce a Age	Const. 8		OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** September 11, 2007 CASTELIA HARRIS MARTINEZ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1timo Balkmore 0 HOUNIS-MAN HINC If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 247-02-6412 1 □ M 2 🛛 F 55 Director 3/25/1952 CAROLINA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show the Medical Examiner must be notified at N/A MD BALTIMORE CITY 1 XYes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 5722 SIMMONDS AVENUE 21215 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) natural", or Items 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ▼ No Specify. Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR TECHNICIAN MEDICAL 12 h and Mental Hygien 7 is marked other tl Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ESSIE HOWARD JOHN EADY ပ Patient lenown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANIE HARRIS / SISTER 3722 LYNDALE AVENUE, BALTIMORE, MD 21213 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. Pages 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 9/13/07 METRO CREMATORY CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licensee 4600 LIBERTY HEIGHTS AVE., BALTIMORE, er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart for the List only one cause on each line. Approximate Interval Between Onset and Death Immed to Cause (Final disea to r condition resulting in death) Pulmonan **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Vascular the death certificate be executed Coronary that initiated events resulting in death) Last buriat-1 Box 68760. Physician/Medical the as attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Ö 9 Unknown ۵. signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 performed? res 2 No certificate 1☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٥ 1 Inpatient 2 PER/Outpatient 3 □ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending After 5 Pending investigation 1 Yes 2 No 2 Accident 3☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 023377

DHMH 17 Rev 1/2001

State Registrar Sinai Hospital of Baltimore

2401 West Belvedere Ave

Mayland 21215

Baltmore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

MAHAJABIN

31. Date filed (Month,

DHMH 17 Rev 1/2001

Registrar

				For State Registrar	State of Maryla	nd / Depa		Health and M	-	ne 2007	29384
		Physici /Medi		1. Decedent's Name (First, Middle, Last Baby Girl Matthe				1	2. Date of Death	Day 8, 200	3. Time of Death 7 1634 M
		Examir		4a. Facility Name (If not institution, give The Johns Hapkins 5. Social Security Number 6. Se	HOSPITAL x 7. Age (In yrs	s. last birthday)		or Location of Death		4c. County of Death	nplace (State or Foreign
3		Director		none Usual Residence of Decedent 10a. State 10b. County	□M 2XIF	Yrs.		Hours 2 Min.	Sept 8, 2	007 Mary	Tand 10d. Inside City Limits
+ her		death with the Maryland ms 23a or 28a-f show	Director	MD 10e. Street and Number		Baltimo	ore 10f. Zip Code		10g.	Citizen of What Cou	1 Y Yes 2 □ No untry?
Tot			Funeral D	3451 June Way 11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		213 Hispanic Origin? (Spe pan, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	USA 14. Race - Amer Black, White	
<	21215-0036	72 hours after natural', or ite iteal Exametra	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi (Specify only highest grace)	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	16a. Dece	1 ☐ Yes 2 ☐ No		na 16b.	Specify: b	lack Industry
JOHNA	12121	filed within 72 Hygiene. other than "nat	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	non	DO NOT use retir	əd)	non		
Supp	Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, Italy.	To Be	Kipchoge Keno Ber 19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Stree		. Matthew	7S	ip Code)
0-0	altimore, Ma	Pages 1 and 2 anent of Health arent of Health arent: If item 27 is ury or other trau		the Johns Hopkins 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 `4 □ Donation 5 ▼Other (Specify,	20b. Removal from State	Place of Dispo	Wolfe St sition (Name of matory or other pla			21287 Location - City or 1	Fown, State
9	Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licens Ronal I S	1/00	Be	ltimore	ess of Facility Comy Board MD 21201	L	altimore	Street
•		Physician /Medical		23a. Part1. Enter the disease, or composite of the compos	ical but sthat caused the decine cause on each line. a. Due to (or as a conse	pren	,	ing, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death Z hrs
	,092	ite be executed by sician and burial-transit and	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	,					
	P.O. Box 68760,	The law requires that the death certificate I ate has been signed by the attending physi page 2 should be detached for use as the I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preging the pregnant at time of good to the pregnant at time of good to the pregnant at time of good the pregnant at time good the good	tal death 3 [Ectopic pregnand Other (specify)	су		23d. Date of deli	very Day Year
		quires that the de sn signed by the a uld be detached f	by	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause g	iven in Part I.	23e. Did tobacc		the cause of death?
	Il Reco	fsician: The law require s certilicate has been sig director, page 2 should b	Completed						24a. Was an autopsy performed	prior to o death?	topsy findings available completion of cause of 2270
	of Vita	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Impatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatier	IL SU DOA		(Check only one) ne 5□ Residence 28d. Describe how in		nify)
	Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) 28e. Place of Injury - At building, etc. (Spec	Injury home, farm, str	M 1	Yes 2 □ No	28f. Location (Street City or Town, St		ral Route Number,
	_	ne Hospital n 24 hours ne Funeral oletely filled	Medical Co		sician: To the best of my kr iner: On the basis of examinand manner stated.						
•		To the within To the comp	Me	29b. Signature and title of certifier			29c, Licer	SS-000	10	Date signed (Month Heurber 8	
				30. Name and address of Pison who co	11a 601) North	Print) h Wolfe	STREET B	saltimore	maryla	,2007 nd21287
		Sta Regist	ate rar	31. Date fifed (Month, Day, Year) SEP 1 3 20	32 Helgistrar's Sign	A An	selle?				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** EXNOVO tember 10 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) or Location of Death Examiner Samare Se HOSPITA rs. last birthday) 8. Date of Birth 5-25-1916 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days 1₩ M 2□ F MARYLAND 91 217-01-3581 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. once. **ESSEX** MD BALTIMORE 1 □ Yes 拓 No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 606 GEORGE AVENUE 21221 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. XXYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Baltimore, Maryland 21215-0036 WHITE Specify: Completed by 3 □Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AGENT INSURANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PHILIP MERLING ANNA (PEARINGER) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MICHAEL MERLING/SON 2716 MAWANI ROAD BALTIMORE, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART JESUS 9-17-2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitCVACH/ROSEDALE FUNERAL HOME ROSEDALE, MD 21237 CHESACO AVE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physician and s the burial-transit To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has b irector, page 2 s autopsy performed death? 2 □ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28h. Time of Certification: 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 ☐ Pending investigation 1 Yes 2 🗆 No neral Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I completely filled 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one)

DHMH 17 Rev 1/2001

Registrar

29c. License number

00045789

29d. Date signed (Month, Day, Year)

and manner stated.

dress of person who completed cause of death (Item 23a) (Type, Print)

9000 strar's Signature

12 Masser

Year) 3 2007

31. Date filed (Month, Day,

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			For State Registrar	State of Marylar		rtificate of		nentai Hy		2007	29386
Ą.	Physici	an	Decedent's Name (First, Middle STANLEY	e, Last)		МТ	LLER	2. Date of Do Month SEPTEME	Day	1 2007	3. Time of Death 8:02P M
	/Medio		4a. Facility Name (If not institution	, give street and number)			r Location of Death	SEFTEME		County of Death	0:UZP
	Funeral		110 SPECTATOR 5. Social Security Number		. last birthday)	OWIN If Under 1 Year		8. Date of Bi	rth	BALTI 9. Birthp	lace (State or Foreign
	Director		218-26-7703 Usual Residence of Decedent	6. Sex 1 M 2 □ F 7. Age (In yrs. 78 8	Yrs.	Months Days	Hours Min.	07/29/	ay, Year) 1929	Cour	MD_
	laryland show ed et		10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				1	Od. Inside City Limits
	ours after death with the Maryls ral", or items 23a or 28a-f shov Examiner must be notified et	Director	MD BALT 10e. Street and Number	IMORE 01	WINGS N	1ILLS 10f. Zip Code			10a Citi:	zen of What Cour	1 □Yes 2 X No
	th with 23a or ust be	al Di	110 SPECTATOR	LANE			1117			USA	,
	ter dea items iner m	Funeral	11. Marital Status 1 □ Never Married 2 [X Marr	12. Was Decedent Ever in U Armed Forces? 1			lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)		14. Race - Americ Black, White,	etc.
2036		þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🛣 No	Specify:			Specify: WHI	
215-(nin 72 h in "natu Medica	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	st grade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of work d)	ing	16b. Kir	nd of Business/Ind	dustry
121	filed within Hygiene. other than	Com	17. Father's Name (First, Middle,	College (1-4or 5+)		SALES	18. Mother's Nam	o /Eirst Middle	Maidan	AUTOM	OBILE
Maryland 21215-0036	ges 1 and 2 should be filed within 72 ho to f Health and Mental Hyglene. If item 27 Is marked other than "natu or other traumatic event, the Medical	To Be	LOUIS	Lasty	MIL	LER	FANNIE		s, Maidell	,	IEDMAN
Mary	d 2 should be h and Mental 7 Is marked of traumatic ev		19a. Informant's Name/Relations	, , , , ,			and Number or Rui		-		
	ss 1 and of Health item 27	8	FLORINE MILLER 20a. Method of Disposition	look	Diana at Diana	-iAi /Ai	LANE, OW	INGS MI Date		MD 211 cation - City or To	
Baltimore,	permit. Peges Department of Importent; If it any Injury or o		1	- A A		HAIM				TIMORE,	
Bal	permir Depar Impor any Ir once.		21. Signature of Funeral Service	Licensee		2. Name and Addre	rss of Facility SO TERSTOWN			& BROS.,	INC. MD 21208
				complications that caused the dea only one cause on each line.						OTTLLL,	Approximate Interval Between Onset and Death
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	Examiner [.]		Sequentially list nonditions	b. CAZONA	en	Brt	Dis	ces	2		
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60,		ŵ	resulting in death) Last	Due to (or as a consec	quence of):						
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Вох	death cer e attendin d for use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregn	al death 3	Ectopic pregnanc	y		2	23d. Date of delive	ery Day Year
P.0.	the d	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of e	death 5L	Other (specify) _					
or Vital Records, F	w requires that the s been signed by the should be detache	Completed by P	Part 1. Other significant condition	ons contributing to death but not res	sulting in the u	nderlying cause giv	ren in Part I.		tobacco u Yes 2	se contribute to th No 3 □ Prob	ne cause of death? eably 4 □Unknown
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or V	di is	ို	examiner?	Hospital: 1 ☐ Inpatient	ER/Outpatier		ner: 4 ☐ Nursing Ho	me 5. X Res	idence 6	6 □Other (Specif	y)
ion	ffel	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig		28b. Time o Injury	Wor	ryat nk? Yes 2 ☐ No	28d. Describe	how injury	y occurred	
Division	al or Attend s after death. Il Director; /	Certification:	3 Suicide 6 Could r 4 Homicide determ		iome, farm, str ify)	eet, factory, office		28f. Location City or To	(Street and wn, State)	d Number or Rura)	l Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical (29a. Certifier (Check only one)	g Physician: To the best of my kn Examiner: On the basis of examin- and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	and due to the rred at the time	cause(s) , date and	and manner as s I place, and due to	tated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certified	Sul Mo)	29c. Licens 0 2	2 44°	4	29d. Date	e siguled (Month,	Day, Year)
	3		30. Name and address of person	wo completed cause of death (Ite	m 23a) (Type,	13/4 E	Bed Dr	1 Au	el	Bally	rais MD
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1	3 2007 32. Podistrar's Sign	ature	Carp -					
DH	MH 17 Rev 1/2			Jan Dan Barrell	NJ AS						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year MCGRAW, JR. **Physician** Sept JAMES HENRY 3:59AM 09 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Shannon Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05 22 1949 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 58 Days 1 M 2 ☐ F 2110.50.4938 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" -- any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore 1 XYes 2 □ No MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3545 Shannor LISA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Mc Com ick 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Boyd James McGraw, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shannon Drive Batto. MD 21213 Diana Mc Graw 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 09/4/07 Baltmore, MD Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addres of Facility Voughin C. Greene Flureral Sentices 21. Signature Funeral Service Ligensee 4905 York Road Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DISEASE ALZHEIMER'S 5 YEARS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): nding physician a P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy atten for u Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours after 155 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

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SEPTEMBER

2000

FERRO, MO 3# Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANDO

31. Date filed (Month, Day, Year)

07-06969 Cathy Martin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

atny Martin		- For State	Certificate o	t Health and Menta <i>f Death</i>		2007	29388
Physiciar	n/	Registrar 1. Decedent's Name (First, Middle, Last)		120411	2. Date of Death	3	Time of Death
Medical Examin		4a. Facility Name (if not institution, give street and num	artin	4b. City, Town, or Location of I	Month September	8, 2007 4c. County of Death	0446 hrs
		Union Memorial	,	Baltimore	,	N/A	_
Funeral Director		245.72.2448 1 M 2XF	Age (In yrs. last birthday) Yrs	If Under 1 Year If Under 2 Months Days Hours	Min. OI 3	Foreign	lace (State or try)
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		(abilled	21	O.C.M.E.		September 9, 200	7
- 8		30. Name and address of person who completed dause Zabiullah Ali, M.D. Assistant Medical	· ·	nn Street, Baltimore, Ml	D 21201		
Star Registra	te	100 m	strar's Signature				

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Physician flature. List only one cause on each line. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Do not enter the mode of dying, such as cardiac or respiratory	altimore nit Pages 1 vartment of H portant: If it	1 🕽	Burial 2 Cremation 3 Donation 5 Other Speci	ify:	ate Avbutus	or other place) Memonal Pa	nk 09/7/07	Baltinio	re, MD
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Signature and diddess of person who completed cause of death (Iter) (23a) Suicide A Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Or Town, State)	ion (tending leath. After the fur	ation 2	rending	9	ear)	1 Yes	s 2 No		
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		2 9b.	Signature and title of certifier	EN!	-				
Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				· ·		Penn Street, Baltim	nore, MD 21201		
State 31. Date filed (Month Day Year) 32. This strar's Signature Registrar		te ^{31. [}	Date filed (Month Day Year)	2007 32. Gistra	r's Signature	Carle			

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	Physicia /Medic		1. Decedent's Name (First Middle, Last) Stephen E. Nassa	ni					2. Date of Dea Month 9/9/	Dav	Year	3. Time of Death 3:00am ^M
7	Examin		4a. Facility Name (If not institution, give st Upper Chesapeake Me	reet and number) dical Center			Town, or Belai	r Location of Death °		4c. Ce	ounty of Death Harford	
	Funeral Director		5. Social Security Number 096-09-6085 6. Sex	7. Age (<i>ln yrs</i> . 92	las <i>t birthday)</i> Yrs.	If Unde Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 12/25/	v, Year)	9. Birth Cou	place (State or Foreign ntry) NY
	pur »		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	e Maryla 8a-f shor tiffed at	ctor	MD Harf		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			st Hill				1 ☐ Yes 21010No
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Her than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	137 German Manor Ro	ad		10f. Z	p Code	21050		10g. Citize	en of What Cou USA	ntry?
	er dea Items	nuel		2. Was Decedent Ever in U Armed Forces?	.S. 13.1	Was Dec If Yes, sp	edent of H ecify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14	I. Race - Ameri Black, White,	
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1717	within 7 jiene. r than "r the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	- life.			during most of work d) Mechanic	ung		Aut	o Repair
and	d be filed ental Hyg ked othe c event ,	To Be C	17. Father's Name (First, Middle, Last) Joseph Nassani					18. Mother's Nam	e (First, Middle, y Calama	Maiden Si Iri	urname)	-
Maryiand	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	F	19a. Informant's Name/Relationship (Typ Teresa Grieshaber		19b. Mailir	ng Addres	ss (Street a	and Number or Ru Manor Ro	ral Route Number d, Fores	er, City or T	Town, State, Zi L1 MD 2	p Code) 1050
Baltimore,	ages 1 an ant of Hea t: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation ③ CRe 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Hol	Place of Disponentery, creed Y ROOD	osition (Na matory or Ceme	ame of other place etery	ce)	Date 5/2007	20c. Loca West West	tion - City or NY bury NY Bury	own, State , NY
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UIVISION	al or Atte al er des l Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, st	reet, facto	ory, office		28f. Location (3 City or Tot	Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours are death: To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)	ician: To the best of my kneer: On the basis of examinand manner stated.	owledge, deal ation and/or in	th occurre	ed at the ti	me, date and place opinion, death occu	e, and due to the arred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			2	9c. Licens	Se number	2	29d. Date	signed (Month	n, Day, Year)
16	5 7		30. Name and address of person who cou	mpleted cause of death (Ite	m 23a) (Type	Print)	Dear	50768 te Dr.	, Belo	217,	MD	21014
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 3 20	32. Registrar's Sign		LSU J	2					

State of Maryland / Department of Health and Mental Hygiene 1- State Amend #30, perDVR, g871, 9/13/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11:19 ^M **Physician** CHESTER SEPTEMBER 8 2007 N. NOTARO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 8002 SAGRAMORE ROAD ROSEDALE BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9 / 1 4 / 1 9 2 1 5. Social Security Number 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MARYLAND 220 07 9764 85 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County If iten 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD BALTIMORE ROSEDALE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8002 SAGRAMORE ROAD 21237 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any injury or other traumate. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo WHITE Specify: \$ 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LINEMAN/ SUPERVISOR LINE SERVICE/STEEL 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be NICHOLAS NOTARO MARIA UNK. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBRA NOTARO/DAUGHTER 8002 SAGRAMORE ROAD BALTIMORE, MD 21237 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
METRO CREMATORY BALTIMORE, MD 9-12-07 4 Donation 5 Dother (Specify) 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Coron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner 0 signed by the attending physician and doe detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de. 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 Dio 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. il Director: After i 5 ☐ Pending investigation injury Patural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer 29c. License number 9.10.07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simon V. Scalia 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year OATS SERTEMBER 11:44 AM 3 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4USPITAL BALTIMORE HANBOR BALTIMORF If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 ☐ M 2 💢 F 215-22-3724 May 29, 1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Grove Park Road 21225 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife & Mother 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Freeze Mary Monahan 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Oats (Son) 1659 Marley Ave., Glen Burnie, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory, Inc. 9/4/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Kevin E Ecker 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. E. Patapsco Ave., Balto., Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DISSEMINATED INTRAVASCHLAR Immediate Cause (Final disease or condition resulting in death) SHOCK AND SEATIC a DAYS COAGULA FON Due to (or as a consequence of): UNOSENSK Cause that the cause if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): END-STAGE NEMAL BISEASE Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? HARNT EAILUNE 2 No 1 ☐ Yes 3 Probably 4 Unknown 24a Was an

Physician /Medical **Examiner**

Department of Health Important; If item 27 any injury or other tr once,

Physician

/Medical

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Funeral

Director

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Pages 1

Director

Funeral

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Completed

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72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Records,

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Examiner Physician/Medical Completed Be Certification: To

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State Registrar

after death Director: filled in by 24 hours a Funeral I within 24 hor To the Fune completely f

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FIBRUCATION 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No BLEEDING plus Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manufer of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1-0001

SEUTEMBER

2007

DHMH 17 Rev 1/2001

TUDOR, LANE, ROCKVILLE, MO,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10.047 POSEN MB 5831 TUBOR LAN

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTE MOER Day **Physician** 5: 11 M 11,200 Owens /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAMORE 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs, last birthday) 5. Social Security Number **Funeral** Min. Hours 1 M 2 □ F Months Davs Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director YMOI 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Des 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nahue 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) mdalaag 20b. Place of Disposition (Name of demetery, crematory or other 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Maday 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYDCARDIAL INFARCTION 45 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CORONARY ARTERY DISEASE Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Physician/Medical the th attending pl IF FEMALE: ed by the attendin-detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔲 Yes 2 🗌 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARYDIS FASE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an LUNG CARCINOMA has autopsy performed: 1☐ Yes 2 No Prostate CARCINGMA director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 35 DOA ၉ 2 ER/Outpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Records, P.O. Box 68760, Division or Vital the Hospital or Attending Physician: within 24 hours a 0

> State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

13

D. 900 SOUTH CATON AVENUE BALTIMORE
32. Registrar's Signature

and manner stated.

joler m.D

and address of person who completed cause of death (Item 23a) (Type, Print)

I.S NYDER MO

200

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 226

29d. Date signed (Month, Day, Year)

MARYLAND

SEPTEMBER 11, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Francis A. Paluskievicz 2007 29394 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 25, 2007 1429 hrs Medical Examiner Francis A. Paluskievicz 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Bayview Medical Center 8, Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Months Days Hours Min Country Maryland Director 215-64-9033 51 19 1956 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2 X No MD Baltimore Dunda1k or 28a-f show items 23a or 28a-f shoust be notified at once. Director 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number 21222 **IISA** 43 Township Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 2 X No Ves 0. Yes 2 X No specify: Specify: white 27 is marked other than "natural", ou umatic event, the Medical Examiner Divorced If Yes. Give Year à 16a. Decedent's Usual Occupation (Give kind of work don unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed timore, MD 21215-0036

E. Pages 1 and 2 should be filed within 72 hou untent of Health and Montal Hygiene repair. If tien 27 is marked other than "nat or other trainmatic event, the Medical East or other trainmatic event, Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis Stanley Paluskievicz Marian Kistner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terry Wolfe/friend 723 S. Bond Street Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State ant: Donation 5) X Other Specify: 22. Name and Address of Facility Signature of Funeral Service Licensee Ronal tate Anatomy Board 655 W. Baltimore Street Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death **Medical** a. Cirrhosis of the Liver Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): b. Due to Alcohol Abuse Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause

Examiner attending physician a signed b certificate h this After

The law requires that the death certificate be executed

Box 68760.

PO

Division of Vital Records,

the Hospital or Attending Physician:

24 hours after death.

To the Fineral

Medical one)

State Registrar

hysician/Medical ð Completed Be Certification: Director:

1 V Natural 2 3

(Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 Other, examiner? Residence 6 DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Yes 2 28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. 2 29b. Signature and title of certifier

(Specify)

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) August 26, 2007

death?

28f. Location (Street and Number or Rural Route Number, City

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of

Month

Year

No

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD.

Pending

Accident

Suicide

29a. Certifier 1

Investigation

Could not be

determined

32. Registrar's Signature 31. Date filed (Month, Day, Year)

or Town, State)

			For State	State of	Marylar	•	artment c			lental Hy	_	2007	0000
		-	Registrar 1. Decedent's Name (First, Middle	, Last)		001	Incate	or Dear		2. Date of De	Reg. No.	2001	3. Time of Death
*	Physici		•	June Pol	k					Month Sept	Day	Year , 2007	4.30 a
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Tov	vn, or Locatio	n of Death	Вере		ounty of Death	14:30 a
eti.	90		622 Hammers	shire Rd			Owin	gs Mi	lls		В	altimo	re
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2√☐ F	7. Age (<i>In yr</i> s. 67		If Under 1 Y	ear If Und	er 24 Hrs.	8. Date of Bi	th	9 Rinth	place (State or Foreign
	Director		513-36-9749	10 M 2/L 1	6 /	Yrs.				June	4,19	40 Ka	ntry) insas
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Mary -f sho fied a	tor	Maryland Bal	timore	Ow	vings	Mills					:	1 ☐ Yes 2 No
	h the r 28a	Director	10e. Street and Number				10f. Zip Co	de			10g. Citize	n of What Cou	ntry?
	th wit 23a o sst be	al D	622 Hammershi	re Rd.			2.	1117			Ū	.S.A.	
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dece Armed For	ces?	J.S. 13.	Was Decedent If Yes, specify	t of Hispanic Cuban, Mexic	Origin? (Sp	ecify Yes or No Rican, etc.)	o- 14	. Race - Americ	
36	safte ;orlt amin	by Fu	1 Never Married 2 Marri	If Yes, Giv	2⊠ No e		1 ☐ Yes 2√☐					pecify: [/] h	ite
Ö	hours tural' al Ex	q pe	3 ☑ Widowed 4 ☐ Divorced 15. Decedent	Year or Da	ites:	16a Dece	dent's Usual O	ccupation			16b Kind	of Business/In	
7	in 72 n "na Nedic	Completed	(Specify only highes	st grade completed)	45-)	(Give	kind of work d DO NOT use re	lone during m etired)	ost of work	ing			
2	y with	mo	Elementary/Secondary (0-12)	College (1	-40r 5+)	Cler	ical/	Custo	mer S	Servic	M.	edical	Supply C
g	e file al Hyg othe	Be C	17. Father's Name (First, Middle,	Last)			•			e (First, Middle		urname)	
<u> </u>	ould b Ment arked aric e	70	Davis S.	McColl	ım				Josej	ohine	Dodge	e	
Maryland 21215-0036	2 sho		19a. Informant's Name/Relations									own, State, Zij	*
e)	1 and Health Sm 27 Iher t		Lisa Marchak 20a. Method of Disposition	- daught		6160	Hidde	en Ho	llow	Dr. S	ykes	ville,	MD. 2178
وت	ages nt of h		1 Burial 2 ☐ Cremation				sition (Name of matory or other						
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service		Lа	revie	W Mem	 Par. ddress of Fac 	K Ser	ot. 1/	, 200	/ Syke	sville, M
Ba	Depri Impo	(i.)	I bank to	lev		1	1605 F	Reist	erst	own Rd	• Ow:	eral C ings M	hapel P.A ills, MD.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the dear	th. Do not ent	er the mode of	f dying, such	as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician	(1)	Immediate Cause (Final disease or condition	My.	elof,	bros	513					1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):							
- 3	LAGITITICI	<u>_</u>	Sequentially list conditions,	b	or as a consec	auchoo of):							
Ţ	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence on.						Į.	
17.	execunand and al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a consec	quence of):							
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			d									
ထ	rtifica ng ph as th	Jedi	IC CEMALE.								T		
Box	ires that the death certifica signed by the attending pl d be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come pf pregn irth 2 ☐ Feta		∃Ectopic pregr	nancy			23	d. Date of deliv Month	
	e des the at red fo	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregn 9□Unkno	ant at time of o	death 5	Other (special	fy)				MOULI	Day Year
P.0	hat thed by detacl		Part II. Other significant condition	ons contributing to de	ath but not res	sultina in the u	nderlying caus	e given in Pa	rt I.	23e. Did	tobacco use	contribute to t	he cause of death?
Vital Records,	uires l signe	d by	Coroner	Arter	1	serse	-	3		1	Yes 2	No 3□ Pro	bably 4 □Unknown
00	w requir been si should	Completed	,)					24a. Was	an I	24h Were autr	opsy findings available
æ	he lav e has age 2 ;	dmo								auto perf	psy ormed?	prior to co death?	impletion of cause of
g	sician; Th certificate rector, pag	Be Co	25. Was case referred to medical					26. Pla	ace of Deat	1 Yes h (Check only	2	1 ☐ Yes	2 □ No
_	Attending Physician: r death. ector: After this certifica by the funeral director, p	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 □ I	npatient 2] ER/Outpatier	nt 3□ DOA	Other:				□Other (Speci	fy)
u 0	ding Pl		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of (Mont	of Injury h, Day Yea <i>r</i>)	28b. Time o Injury	f 28c.	Injury at Work?		28d. Describe	how injury	occurred	
Sio	tendi eath. tor: A the fu	catio	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	jation			М	1 ☐ Yes 2	□No		la		
Division or	or At after d Direc in by	Certification:	4 Homicide determ	ined Zoe. Place	of injury - At n ng, etc. <i>(Speci</i>		eet, factory, of	fice			(Street and I wn, State)	Number or Rur	al Route Number,
	spital ours a neral filled		29a. Certifier 1 - certifyin	g Physician: To the	best of my kn	owledge, deat	h occurred at t	he time, date	and place.	and due to the	cause(s) a	nd manner as s	stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical one)	Examiner: On the ba	asis of examin er stated.	ation and/or in	vestigation, în	my opinion,	death occur	red at the time	, date and p	lace, and due	to the cause(s)
	To t To t	Ž	29b. Signature and title of certifier	10				cense numbe			al	signed (Month,	Day, Year)
)				_ / \		V-')	\ \mathcal{V}	271°	L 5		9/10	(0)	
	10		30. Name and address of person	who completed caus	e of death (Ite	m 23a) (Type,	\mathcal{D}_{e}	. ط	(Ani	~.	и э	211	2 (
	Sta	te	31. Date filed (Month, Day, Year)	2. R	egistrar's Sign	ature		リヤイ	J. 1 0		_ "	211	3 (
	Registr		SEP 13	2007	1000 10	ature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Ng2 0 Decedent's Name (First, Middle 2. Date of Death Month **Physician** /Medical acility Name (If not institution, give street 4b City, Town, or Location of Death County of Death Examiner 7. Age Birthplace (State or Foreign Country) 6. Sex last birthday 8. Date of Birth (Month, Day, Year) Funeral 9. Days Hours Min 1□M 2√2F Yrs. Director 219-28-9534 30 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelin and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a arrestonent in the marked other than "natural". 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD Baltimore 1 ☐ Yes Ž No Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 701 Edmondson 21228 Ave U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2♥ No Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Clerk Dept. of Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည James J. Liberto Lena A. Natkvs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 896 Evergreen Road, Southern, Md 21144 Norma Anderson-Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Qonation 5 ☐ Other (Specify) 9/14/07 Glen Haven Glen Burnie of Funeral Service Licensee 21. Signi 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lating. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Photo Solos ofic Due to (or as a consequence ol): **Physician** /Medical Examiner tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of): Examine inding physicien and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 200 No 1□ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After the 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation death. serel Director; A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire To the Hospitel 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NAGCOM 15503

State

Registrar

DOLPHIN ST BALTIMER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date liled (Month, Day, Year)

SEP 1

IAZEM

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10, ^{Day}007 Sept **Physician** Terry Ann Raum 11:07 A M /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, Sept 9, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Yef 956 Washington DC 1 🗌 M Director 217 66 1714 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 Tes No Fort Washington Prince George's Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20744 11013 Riverview Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married 1 ☐ Yes 2XXVo Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Asst. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Joseph Thomas Hilda Irene Montgomery 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11013 Riverview Road, Fort Washington, MD 20744 Tracy A. Raum (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept 12, Date 2007 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State Dunkirk, Maryland 4 □ Donation 5 □ Other (Specify) Lee Funeral Home Grematory 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility ee Funeral Home, Inc 6633 Old 20735 Alexandria Ferry Road, Clinton, MD 1701391 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER Physician METASTATIC 90 DAYS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if only leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an sate has b autopsy perform director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 24 hours after death e Funeral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu and title of certifier 28281 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NELSON BENTERS, 9131 P1 PISCATAWAY ROAD, CLINTON, MD 90735 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Bettylou C. Rohnacher . SEPTOMBE 10,2007 7:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Dec 20, 1 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days MD Country) Hours 1 M 2 M F 217-26-7372 76 1930 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 Ho Directo Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 33 Darrow Drive Funeral 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 0 1 ☐ Yes 2 ☐ No Specify. þ 3₺ Widowed 4 Divorced white "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) medical office secretary event, tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Norman Sowers Rose Emma Urie 2 19a Informant's Name/Relationship (Type Print)
Christina Rose Rohnacher, daugh, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 Leeds Ave., Arbutus, Md. 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National 9/13/07 Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sterling Ashton Schwab Witzke 1630 Edmondson Ave., CAtonsville, Md. 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DISSECTION ADRTIC HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION YEARS Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ⊑Yes 2 🗷 No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s autopsy performed 1 Yes 2 No Hospital or Attending Physician: in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Registrar

State

24 hours a

within 2

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

SOHNACHER

29a. Certifier

(Check only one)

JOSEPH

29b. Signature and title of certifier

Medical

and manner stated.

an

32. Régistrar's Signaturé

Intermely in

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TWANMOH

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

046505

ST. AGNES HOSPITAL BALTIMORE, MARYLAND

29d. Date signed (Month, Day, Year)

SEPTEMBER 11, 2007

SAID IN DE: SILVAN KIDAKON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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3			SINAI HOSPITAL 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	BALTIMORE If Under 24 Hrs.	8. Date of Birth	9 Birthn	N/A lace (State or Foreign
	Funeral Director		213-01-2534 ¹ 况 ^{M 2□ F}	90 Yrs.	Months Days	Hours Min.	04/13/191	(ear) Coun	MD MD
	yland now at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			1	0d. Inside City Limits
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	with the	Dire	10e. Street and Number 3418 WOODVALLEY DRIVE		10f. Zip Code 21208		10g	Citizen of What Coun	itry?
336	be filed within 72 hours after death with the Maryland Ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 Narried If Yes, Give Y Year or Dates:	o 13.	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Spi in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
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מש	e filed al Hygi other rent, tl	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma	iden Surname)	
ylar		ם	EDWARD			MARY			KALUS
Maryland	ar is	П	19a. Informant's Name/Relationship (Type. Print) ISABELLE RIBAKOW / WIFE					City or Town, State, Zip BALTIMORE	-
			20a. Method of Disposition	20b. Place of Dispo	T. WILSON psition (Name of matory or other place	- 1		oc. Location - City or To	
Baltimore,	permit. Pages 'Department of H Important: If Ite any Injury or of		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	OHEB SHAL	OM MEMORI	AL 09/1		EISTERSTOW	
Bai	permit Depar Impor any In once.		21. Signature of Funeral Service Licensee		2. Name and Addres	301		N & BROS., KESVILLE,	
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P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	,		23d. Date of delive Month	ery Day Year
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Division or	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	- C	ry - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Rure State)	al Route Number,
	e Hospit 24 hours e Funera etely fille	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of and manner sta	examination and/or in					
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	10		30. Name and address of person who completed cause of de		Print) NU.	Ballim	ore, MA	2/201	
	Sta			ar's Signature		(v .		¥	
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DHMH 17 Rev 1/2001

07-07010 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles D. Stevens State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical Examiner 1459 hrs September 9, 2007 harles 4a. Facility Name (if not institution, give street and numb) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral Months Days Hours Min. Director Country) M 2 unaverlable Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No must be notified at once Director 10e. Street and Numbe 4205 238 Funeral 11. Maritat Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ricarr, etc.) 1 Never Married 2 Marrie 2 - No Yes Pages I and 2 should'be filed within 72 hours after prent of Health and Mental Hygiene. Int. If item 27 is may ked other than "natural", or other traumatic event, the Medical Examiner or prother traumatic event, the Medical Examiner or 2 No specify: Widowed Divorced If Yes, Give Year Yes Specify: ack \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden To:Be ace 19b. Mailing Address Town, State, Zip.Code) 9 2074 UBEV Place of Disposition (Name of Method of Disposition more, crematory or other place Burial 2 Cremation Removal from State Baltimol permit Pages Department of Important: I Donation 5 Other Specify: nature of Funeral Service Licenses Approximate Interval **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Between Onset and /Medical Death Narcotic intoxication and cocaine use Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funcral Director: After this certificate has been signed by the attending physician and Physician/Medical X UNPENDED attending physician or use as the burial -9/13/07 TT/ #23a.27.28a-f. per ME,C871 9/19/07 TI Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury (Month, Day,Year 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural 1 Yes 2 X No Pending Fnd 9/9/2007 FNd 2:05 pm filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide 4205 58th Ave. Bladensburg, MD (Specify) found in residence Homicide 29a. Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 10, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

DOME

SAID TO BE: SONDRA SAPPERSTEIN Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend 4a, perMD, 10e, 19b, perFH, 0871, 9/18/07 TT te of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER 10 SONDRA ELAINE SAPPERSTEIN 2007 11:15 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3300 STONE CLIFF DRIVE #406 BALTIMORE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 07/14/1934 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 ₩ F Yrs. 216-30-9617 73 MD Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE BALTIMORE 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 3300 STONE CLIFF DRIVE #406 21209 U.S.A. Funeral death Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No WHITE 9 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumant. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 EMANUEL STRAUSS ETHEL 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3000
3000
STONE CLIFF DRIVE #406 - BALTIMORE, MD 21209 19a. Informant's Name/Relationship (Type. Print) GILBERT SAPPERSTEIN/HUSBAND 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CONG 09/12/2007 REISTERSTOWN, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee devens 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deam shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Caset and Death Immediate Cause (Final disease or condition resulting in death) ancreadic Cancer Physician mouto /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, that it is a sequentially list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Nnknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No has certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 217 10 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 2 🗌 No 1 🗌 Yes investigation ie Hospital or Attendi 24 hours after death. ie Funeral Director: A 2 Accident filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 11, 2007 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers. Q CIO 31. Date filed (Month, Day, Year SEP 1 3 Year) State

Registrar

07-06984									
Folicia	Δ	Spratley							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Dissolation Coloration Co		у	1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death Reg. No. 2007 2940
5 Social Security Number Col. Color Col. Prince Col			1. Decedent's Name (First, Middle, Last) FELICIA A. SPRATLEY 2. Date of Death Month Day September 8, 2007 3. Time of Death 1630 hrs
Security Agents of the security of the securit			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
South Annual Part County 1	Director	-	219-08-249 1 M 2XF 22 F 22 Yrs. AUG: 4.1985 Country MARYLAND
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150 150	er death wil	Funera	1 Never Married 2 Married 2 Married Armed Forces? 1 Yes 2 No
A Second Companies of Compani	2 hours afte "natural" [Examine		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)
A Second Companies of Compani	o-UUSO ed within 7 fygiene. other than	Comple	12 THERADE CLERICAL BANK
22. Name and Address of Fashing 22. Name and Address of Fashing 23. Name and Address of Pearling 24. Name and Add	nould be fill and Mental Fils marked	Be	TEROME HOLMES LISA ANN PARTLOW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22. Name and Address of Fashing 22. Name and Address of Fashing 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course) 22. Name and Address of Person who completed cashs of death (Durk Course)	s I and 2 sl f Health ar If item 27 ter frauma	-	2 200 Education City of Tolkin, Oldice
Part Female Fem	rmit, Page epartment on portant; jury or ott	-/	4 Donation 5 Other Specify: MT. ZION CEMETER 09-15-07 LANSDOWNE, MD 21. Signature of Funeral Service License: 22. Name and Address of Faility: Brown TR FUNERAL HOME.
Amendate Cause (Final alleases of condition resulting in death) Leading to immediate and course of the control of the course of	hysician		Part I/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest; shock, or heart Approximate Interval
The transport of the properties of the propertie	_	4	or condition resulting in death) Due to (or as a consequence of):
UNPENDED Second		miner	fi any, Jeading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1	xecuted n and I - transit		d.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1	ifficate be on physicial as the burial	n/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) September 9, 2007	e death cerr the attendir ed for use a	hysicia	past 12 months? 4 □ Pregnant at time of death 5 □ Other (Specify) g □ Unknown
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and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) September 9, 2007	tending Preath. tor: After the funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Sep 8, 2007 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Subject shot
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) September 9, 2007	pital or Ar ours after d reral Direc filled in by	Certific	3 Suicide 6 Could not be determined Coperify Sidewalk 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Sidewalk 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Sidewalk 28f. Location (Street and Number or Rural Route Number, City or Town, State) #6 Silerton Road Apt.2B, Baltimore, MD
30. Name and address of person who completed cause of death (Item 23a)	To the Hos within 24 h To the Fur completely	edical	(Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Additional Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		Σ	Theodore of the My many O.C.M.E. OCME September 9, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician JOSEPH BERNARD SMITH, JR. 20:15 PM SEPTEMBER 8,2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A St. Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Yrs. Maryland Mar 29, 1934 Director 220-30-3788 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No 28a-f sh notified Baltimore Director N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or be 21230 USA 2507 Frank Avenue "natural", or items 23a edical Examiner must b Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Folces. 1 Yes 2 No If Yes, Give Year or Dates: 1956-58 1 Never Married 2 Married 1 ☐ Yes 2 ☐ ¥No Specify: Specify Baltimore, Maryland 21215-0036 q 3 Widowed 4 Divorced White Completed h and Mental Hygiene. 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Allied Maintenance Mechanic 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H Be Joseph Bernard Smith, Sr. Anna Marie Shook ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health an. Important: If item 27 is m. any injury or other 1 (WIFE) 21230 2507 Frank Ave., Baltimore, Maryland Charlotte E. Smith 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 9/11/2007 Woodlawn Cemetery 21. Signature of Euneral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART FAILURE Physician DAYS CONGESTIVE /Medical Due to (or as a consequence of): Examiner MOUTHS ARTERY CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed MONTHS CBSTRUCTIVE AIRWAY CHRONIC Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, SFAG Physician/Medical RENAL PAILURGE CHRONIC ACUTE ON IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performe death? 1 ☐ Yes 2 No 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Inpatient 1 ☐ Yes Certification: To After this 28b. Time of 27. Manyer of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director; 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

DHMH 17 Rev 1/2001

Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

28 mm alitanvari, mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

9150

CATON AVENUE, BACTIMORE, MP, 21229

29d. Date signed (Month, Day, Year)

SEPTEMBER 8, 2007

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone.

Physician /Medical Examiner To Be Completed by Funeral Director

_ State				tment of lificate of				_			
Registrar 1. Decedent's Name (First, Middle, L	.ast)		Certi	ilicale of	Dealli		2. Date of D	Reg. N	201	07	29401
Alfred J. Simpson							Month Septem	D		Year	12:50 PM
la. Facility Name (If not institution, gi		er)	-	4b. City, Town,	or Location of		осресы		c. County		12.50 FM
Stella Maris Hosp				Timon				E	alti	nore	
5. Social Security Number 6. 215–50–3508	Sex 1 M 2 □ F 7.	Age (In yrs. last birt 59		If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bi	ay, Year		Cour	
Usual Residence of Decedent							Aug 24	, L	948	Mary	land
Oa. State 10b. County Anne A	Arundel	10c. City, Town								1	1 ☐ Yes 2 No
0e. Street and Number				10f. Zip Code				10g. C	itizen of W	/hat Cour	ntry?
1304 Hollow Glen	Court				21226				US	SA	
1. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date:	s? X.No		as Decedent of I Yes, specify Cut ☑Yes 2🌠 No		in? (Spec Puerto F	cify Yes or Na Rican, etc.))-		k, White,	ean Indian, etc.
15. Decedent's E	Education	16a.		nt's Usual Occu		_		16b. l	Kind of Bu		
(Specify only highest grades) Elementary/Secondary (0-12) 12	rade completed) College (1-4c) 4		life. DO	nd of work done NOT use retire enginee:	d) -	of workin	g		onst		
7. Father's Name (<i>First, Middle, Las</i> Alfred Jabez Si	•				1		(First, Middle			e)	
9a. Informant's Name/Relationship Jennifer C. Simp		e 19b.	Mailing A	Address (Street Hollov	and Number Glen	or Rural	Route Numb	er, City	or Town, S	State, Zip	Code) 1226
0a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 { 4 ☑ Donation 5 ☐ Other (Special) 1. Signature of Euneral Service Lice	eity)	20b. Place of cemeter	y, crema	tory or other pla		Da	ate	20c. L	ocation - 0	City or To	own, State
Ronald S.	Wade Di		Sta Bal	Name and Addre te Anat timore,	omy Bo MD 2				ltimo	re S	treet
23a. Part1 Enter the disease, or conshool or heart failure. List only	plications that caus	ed the death. Do n	ot enter	the mode of dui				FFOCT			Approximate
	y one dade on each	mic.		ine mode or dyr	ng, such as c	ardiac or	respiratory a	irest,			Interval Between
mmediate Cham Final disease or condition	a. NON SM	ALL CELL as a consequence o	LUNG			ardiac or	respiratory a	irest,		-	Interval Between Onset and Death
mmediate C Final disease or condition esulting in death)	Due to (or a	ALL CELL as a consequence o	LUNG			ardiac or	respiratory a	irrest,			Interval Between
mmediate C. Final disease or condition esulting in death) Sequentially list conditions, and leading to immediate cause. Enter Underlying cause (Disease or injury hat initiated events	a. NON SM Due to (or a	ALL CELL	LUNG			ardiac or	respiratory a	inest,			Interval Between
Immediate C Final disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last	a. NON SM Due to (or a	ALL CELL as a consequence o	LUNG			ardiac or	respiratory a	inest,			Interval Between
mmediate C. Final disease or condition esulting in death) Sequentially list conditions, fany leading to immediate ause. Enter Underlying Jause (Disease or injury hat initiated events esulting in death) Last	a. NON SM Due to (or a) b. Due to (or a) c. Due to (or a) d. 23c. If yes, outcom 1 Live birth	as a consequence of as a consequence of as a consequence of the pregnancy 2 Fetal death at time of death	LUNC of): of):			ardiac or	respiratory a	inest,	23d. Date Mon		Interval Between Onset and Death
Immediate C Final disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Dause (Disease or injury hat initiated events esulting in death) Last F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. NON SM Due to (or a) b. Due to (or a) c. Due to (or a) d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	as a consequence of a consequence of a consequ	LUNG of): of): 3 Ec 5 O	ctopic pregnanc	y	ardiac or	23e. Did 1		Mon use contri	th	Interval Between Onset and Death Pry Day Year De cause of death?
mmediate C. Final disease or condition esulting in death) Sequentially list conditions, i any, learlin, to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	a. NON SM Due to (or a) b. Due to (or a) c. Due to (or a) d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	as a consequence of a consequence of a consequ	LUNG of): of): 3 Ec 5 O	ctopic pregnanc	y	ardiac or	23e. Did t	obacco Yes 2 an osy	Monuse contril	bute to th	ery Day Year ably 4 Nunknown psy findings available mpletion of cause of
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

31. Date filed (Month, Say

29b. Signature and title of certifier

TARIQ MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 2300 DULANEY VALLEY RD.

32. Registrar's Signature

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

			For State of State of Registrar	Maryland / Dep <i>Ce</i>	partment of F Partificate of		, ,	iene _{eg. No.} 2 N N	7 201.05
ı		÷.	negistrar 1. Decedent's Name (First, Middle, Last)		or imodio or	Douth	2. Date of Deat	h	3. Time of Death
	Physici /Medic		Estella H.	S	chwaab		Septemb	er 7, 200	
	Examin		4a. Facility Name (If not institution, give street and nun	nber)	7	r Location of Death		4c. County of Do	
		W 14	Lorien Nursing Home 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Mt. Air	y If Under 24 Hrs.	8. Date of Birth	Carrol1	County Birthplace (State or Foreign
	Funeral Director		219-20-6069 ^{1□M 2} 5 F	81 Yrs.	Months Days	Hours Min.	(Month, Day, May 22,	1926 Ma	Country) aryland
	ryland how at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location				10d. Inside City Limits
	e Ma 8a-f s	Director	Maryland Frederick	Monrov	'ia				1 □ Yes 2 No
	with the	Dire	10e. Street and Number 11913 Mill Brooke Ct.		10f. Zip Code	720	10	0g. Citizen of What USA	Country?
	ns 23	Funeral		dent Ever in U.S. 13			ecify Yes or No-		merican Indian,
12-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	Armed For 1 □ Never Married 2 □ Married 1 □ Yes 3 ☑ Widowed 4 □ Divorced Year or Da	2⊠No e	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an', Mexican', Puèrto Specify:	Rican, etc.)	Black, W Specify: V	thite, etc. Vhite
ဂ ဂ	72 hc "natu dical	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Dec (G/i	cedent's Usual Occup ve kind of work done . DO NOT use retired	pation during most of worki	ing	16b. Kind of Busine	ss/Industry
7	within ene. than he Me	Completed	Elementary/Secondary (0-12) College (1-12)	-4or 5+)	ne Manage	*		Catalog	Sears
0	il Hygi other ent, t	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, N		
/land		10 B	James E. Sche	afer		Estell:	a	М.	Alitz
nar)	2		19a. Informant's Name/Relationship (Type. Print)		iling Address (Street				e, Zip Code)
e 'e	1 and Health em 27		Ray Fewster 20a. Method of Disposition		9 Dawn Dr position (Name of rematory or other place			21740 20c. Location - City	or Town, State
Saltimor	Pages ment of ant: If It ury or c		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)		ematory or other place Park Cemet	ery 9/11	/07 B	altimore,	, Maryland
ממ	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee		22. Name and Addre 3620 Wilk			rk Funera re, MD 21	
(b)	Physician /Medical		23a. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition resulting in death)	D STAGE	enter the mode of dying	ng, such as cardiac o	or respiratory arre	L failur	Approximate Interval Between Onset and Death
	Examiner		V se	or as a consequence of):	, E Ch	rome ab	struth	re long,	ZWK
	ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence of): 1	2/02				YKS
00/00	ficate be executed physician and the burial-transit	edical Ex	resulting in death) Last Durb (or as a consequence of):	rillati	8n			URS
õ	rtificat ng phy as the		IE EEMALE.						
.O. BOX	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	in the pact 12 months?	ant at time of death 5	B Ectopic pregnancy Other (specify) _	У		23d. Date of o	delivery Day Year
cords, P	requires that the een signed by th	by	Part II. Other significant conditions contributing to de	ath but not resulting in the	underlying cause giv	en in Part I.	23e. Did tob		e to the cause of death? Probably 4 □Unknown
Ď L	The law re ate has bee page 2 sho	Completed	MISTORY Of Cerebi	" ANXIETA	Desces	ción	24a. Was ar autops perform 1 Yes 2	y prior	
2	cian: ertifica ector,	Be C	25. Was case referred to medical examiner?	///	1011	26. Place of Death			
5	Physic this cral dire	: To	1	npatient 2 ER/Outpatient 2 Bb. Time		4 Light Nursing Ho		nce 6 Other (S	pecify)
5	ding th. : After ; funer	tion		h, Day Year) Injury	Wor	k? Yes 2 □ No	zou. Describe no	w injury occurred	
	al or Atter after deai I Director d in by the	Certification:	3 Suicide 6 Could not be 28e. Place	of injury - At home, farm, s ng, etc. <i>(Specify)</i>	street, factory, office		28f. Location (Str City or Town	reet and Number or , State)	Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the ba and mann	asis of examination and/or	ath occurred at the til investigation, in my o	me, date and place, opinion, death occuri	and due to the ca red at the time, da	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
}	To th within To th	Me	29b. Signature and title of certifier	lly hs	D 29c Licens	474	9 25	Sept	1.00
	di		AllEN Keilly, M.	e of death (yem 23a) (Type	e, Print) //	ose A	ve, FR	reperio	7 2007 CK, Md21701
	Sta Registr		31. Date filed (Month, Day, Year) 32 Re	egistrar's Signature	all s				

1. Decedent's Name (First, Middle, Last) 2. Date-Month Medical Examiner 4a. Facility Name (If not institution, give street and number) 301 McMechen Street Apt 201 Funeral Director 5. Social Security Number 2. Date-Month O9 4b. City, Town, or Location of Death Baltimore 5. Social Security Number 6. Sex 7. Âge (In yrs. last birthday) Yrs. Months Days Hours Min. O5	n Da		
Medical Examiner Earl Alexander Smith O9	3.0	ay Year	3. Time of Deam
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301 McMechen Street Apt 201 21217 11. Marital Status 1 Never Married 2 Named Forces? 1 Never Married 2 Named Forces? 1 Never Married 2 Named Forces? 1 Never Married 2 Named Forces?	or No- :.)	14. Race - Am Black, Whi	
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Tr. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) William Smith 19a. Informant's Name/Relationship (Type. Print) Personal Street and Number or Rural Route Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) William Smith 19b. Malling Address (Street and Number or Rural Route Name) Reverse App. Jackson Bangana (First, Middle, Last) Reverse App. Jackson Bangana (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19b. Malling Address (Street and Number or Rural Route Name)		or Town State	Zin Code)
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Beverly Ann Jackson-Daughter 3608 Fairview Ave, B 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition		Location - City o	
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4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lineage And Donation 5 Other (Specify) Carrison Forest Vet 9/18/ 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Bal	timor	DM or	21215
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat shock, or heart failure. List only one cause on each line		e/ na	Approximate Interval Between
Physician Immediate Cause (Final disease or condition ALZ HeIMER'S Demantia			Onset and Death
/Medical resulting in death) Due to (or as a consequence of):			
Examiner Capping L Juss Rely Hama			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
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o Be	Walter	Coope	er						Ire	ne T	heodo	re			
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은		West	Ho	ospital:	Inpatient 2	☐ ER/Outp	atient 3	DOA Oth	er: 4□N	ursing Hon	ne 5 The	sidence	6 🗆 🗆	ther <i>(Sp</i> ec	ify)
				28a. Date	of Injury th, Day Year)	28b. Ti	me of ury	28c. Injur Wor	y at	2	8d. Describe	how inj	ury occu	rred	
atic	2 Accident		igation	,			М	1 _	Yes 2□]No					
2 Accident Investigation 3 Suicide 6 Could not be determined determined building of Specific Street and Number 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number building of Specific)										2	8f. Location City or To	(Street a	and Num	ber or Rui	ral Route Number,
Ξ	4 Homicide		1		ing, etc. (Spec	,,					Ony or 1	Jim, Ola	10)		
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dical Certification:	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cedifier (29d. D	ate sian	ed (Month	, Day, Year)
Medical Certif	29b. Signature and	1 title of coutifie	O A	10	2	A A ()				. 0/		- 1	_	,	
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		ul	u		se of death (Ite	em 23a) (T	ype, Print)				DAIN	2	MT	200	911
	29b. Signature and	ress of person	who com	MIC	se of death (Ite	419	ype, Print)	D26			PALT	0	NJ-	200	91 <u>J</u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #19a,perInf,g871, 9/17/07 TT Certificate of Death 29408 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 09 05 19:35 Ronald 2007 Eugene Steele /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner 3805 Grantley Road Baltimore 5. Social Securify Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 50 Director 212-76-8509 18 56 SC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified one. 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 √Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race - American Indian Funeral 3805 Grantley 21215 Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☐ No If **Ye**s, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Benefit Authorizer</u> Social Security Adm. 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pauline Watkins Mack Dewitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keta Stello-Wife 3805 Grantley Road, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 9/12/07 Owings Mills, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West als 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of); Examiner IUCY Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): epatitis To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Due to (or as a consequence of) been signed by the attending physician a should be detached for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No certificate has birector, page 2 st autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) ျှ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) funeral 27. Mannet Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation within 24 hours arten control to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

S. Evence

23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

31. Date filed (Month, Day, Year)

			For State	State of Marylan	-				0.00	=
		-	Registrar 1. Decedent's Name (First, Middle, Lac	st)	Ce	rtificate of	Dealli	2. Date of Dea	Reg. No. 2 6 0	7 29109
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	Examir		4a. Facility Name (If not institution, give GILCHRIST HOSI			4b. City, Town, o	r Location of Death		4c. County of D	eath TIMORE
	Funeral Director		5. Social Security Number 6. S		last birthday) 6 9 Yrs.			8. Date of Birtl 7 – 16 – 1	h 9.	Birthplace (State or Foreign Country) ARVIAND
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	a-f sho	ctor	MD BA	ALTIMORE			ROSEDA	LE		1 ☐ Yes 2 X No
	with the	Funeral Director	10e. Street and Number 1502 CHESACO A	VENITE		10f. Zip Code	21237		10g. Citizen of What	
	ms 23	neral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	U.S	merican Indian,
215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	þ	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		IT Yes, specify Cub. 1 ☐ Yes 2 【XNO	an, Mexican, Puerto	o Rican, etc.)		WHITE
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Baltimore,	Pages 1 aument of Hea ant: If Item ury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	emetery, crei DAR H		ETERY 9-		20c. Location - City BROOKL	YN, MD
Balt	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Lice	see			ss of FacilityCVA		EDALE FU EDALE, N	NERAL HOME D 21237
	Physician		23a. Part1. Enter the disea , or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death one cause on each line. PCRITONCE	1		ng, such as cardiac		rest,	Approximate interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):		1			
*	D #=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	uence of):					
	ecuter and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ	ience of):					-
68760,	cate be ex physician the buria	edical E	· ·	d	201.00 0.7.					
Box.	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 N No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3	Ectopic pregnancy	y		23d. Date of Month	delivery Day Year
ds, P.O.	uires that signed by Id be deta	by	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderly ing cause giv	en in Part I.	23e. Did to	1.7	e to the cause of death? Probably 4 Unknown
or Vital Records,	The law require ate has been sig page 2 should b	Completed						24a. Was a autop	sy prior med? deat	
ital		Be C	25. Was case referred to medical examiner?				26. Place of Dea		2 No 1 □ 1	Yes 2□No
or V	Phys this	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatier		4 LI Nursing H		ence 6 10 Other (5	specify) NOSPICE
ion	ding After fune	ation	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2□No	Zou. Describe fi	ow injury occurred	
Division	Hospital or Attending 24 hours after death. Funeral Director; After tely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined		28f. Location (S City or Tow	treet and Number of n, State)	r Rural Route Number,			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	(Check only 2 ☐ Medical Exam	ysician: To the best of my kno- niner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	ppinion, death occu	rred at the time,	date and place, and	due to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier			29c. Licens	e number	4	29d. Date signed (M	onth, Day, Year)
,	7		20. Name and address of access the	completed cause of death //	23a\ /T	Print)	70205		SEPTEMIN	cr 11 200/
2	0		30. Name and address of person who	URS WD 6701	N.C	lurles Si	+ TOWSON	MD	21204	
	Sta Registr	_	31 Date filed (Month, Day, Year) SEP 1 3	completed cause of death (Item 2007 32. Restrar's Signa	ture	first.				

DHMH 17 Rev 1/2001

Slaysman, Hulda M., Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

				ype or Prin						-		-	le.		
		1 - For State Amend Registrar	l PI, line c	State of Ma perMD,G871,	arylan 9/13,	d / De /07 17	partment o ertificate o	of Hea of Dea	Ith and N ath			20	07	294	10
Physicia /Medic		1. Decedent's Name	e (First, Middle, Last)	wgavet	(Slay	Isman			2. Date of De Month	Day		Year	3. Time of D	A M
Examin		4a. Facility Name (I	f not institution, give s	street and number)	Cer	ker	4b. City, Tow	4 .	ation of Death		-	County o		ore	
Funeral Director		5. Social Security N	1		e (In yrs. I	ast birthda Yrs.	y) If Under 1 Y	ear If U	Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da	ay, Year)		9. Birthp Cour	lace (State or I try)	Foreign
70		Usual Residence of			10c. City	, Town or	Location	1		0-22-				0d. Inside City	Limits
Maryla a-f sho	tor	MD.	BALTIMO	RE		SEDA								1 □Yes 2	
with the a or 28	Director	10e. Street and Nur 1 2 0 7 6 3					10f. Zip Co				10g. Citizen of What Country? U.S.A.				
death	Funeral	12.07 0.		12. Was Decedent I Armed Forces?	Ever in U.	J.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race	- Americ	an Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Marri 3 🌠 Widowed	ied 2 Married 4 Divorced	1 Yes 2 N If Yes, Give Year or Dates:	No WW:	II	1 □ Yes 💥	No Sp	ecify:	riidan, etc.,		Specify:	WHI	re	
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d be fillental H	To Be	17. Father's Name								e (First, Middle UNKN)		Surname)		
2 should be and Mental is marked c	ř		ame/Relationship (Ty)	pe. Print)		19b. Ma	ailing Address (St.					r Town, S	tate, Zip	Code)	
1 and Health em 27 ither tr		FRANK X 20a. Method of Disp	. SLAYSMA	AN Jr.(S	20b. P.	lace of Dis	7 N. 63	of	1	Date	20c. Lo	cation - C	ity or To	wn. State	
Pages nent of H int: If ite iry or of	į		☐Cremation 3 ☐R 5 ☐ Other (Specify)	emoval from State	GA	emetery, c RDEN	rematory or other SOFFA	r place) ITH	09-0	5-2007	BAL	TIMO	RE,	MD.	
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Physician /Medical Examiner	0 19	23a. Part1. Enter the shock, or head Immediate Cause (disease or condition resulting in death)		Due to (or as	a consequ	Do not e								Approximate Interval Betwee Onset and De	en eath
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ficate be executed physician and s the burial-transit		resulting in death) l	Last	Due to (or as		uence of):									
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uires that the de signed by the a ld be detached f	þ	Part II. Other signif	ficant conditions cor	ntributing to death b	ut not resu	ılting în the	e underlying cause	e given in	Part I.	23e. Did 1		_		ne cause of dea	
: The law require cate has been si , page 2 should b	Completed									24a. Was auto perfo		de	eath?	psy findings av mpletion of cau	railable ise of
	Be C	25. Was case refer examiner?	i .	la anién la					Place of Deat	h (Check only					
g Physl ter this c teral dire	n: To	1 ☐ Yes 2x	th	lospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Date	ry	ER/Outpat 28b. Time Injur		Other: 4 Injury at Work?	☐ Nursing Ho	ome 5 Resi 28d. Describe				y)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	1 Natural 2 □ Accident 3 □ Suicide 4 □ Homicide	5 ☐ Pending investigation 6 ☐ Could not be determined	28e. Place of injubuilding, etc			М	1 Tes	2 □ No	28f. Location (City or To			r or Rura	Il Route Numbe	er,
e Hospital 24 hours a e Funeral letely filled	edical Ce	29a. Certifier (Check only one)	1 Certifying Phys		f examinat										
To the within To the compl	Me	29b. Signature and	Hitle of certifier	Red Q) m	.0.		ol4			29d. Date	e signed	(Month,	Day, Year)	x07
7		2	ress of person who co	ompleted cause of d	eath (Item	23a) (Typ	De, Print)	7	Cive T	1617		Cons	2/2	27	
Sta		31. Date filed (Mon	oth, Day, Year)	32. Registra	ar's Signat	ture	10040	ار ح	1117	77 ("M)	210	VVID	014	0 /	
Registr	ar		NEF IN C	101 34 - 1810		q	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:30 AM Steinberg Physician braham ptember 10 /Medical 4a. Facility Name (If not institution, give street and number)
Battimore Rehabilitation Extended 4c. County of Death 4b. City, Town, or Location of Death Examiner (avz BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours 1 M 2 □ F 215-12-7746 85 07/09/1922 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show must be notified at 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ö 21209 6617 DEANCROFT ROAD U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Black, White, etc. 1 √Yes 2 No If Nes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No WHITE Baltimore, Maryland 21215-0036 Completed by 3 X Widowed 4 ☐ Divorced 'natural", 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BENEFIT CLAIMS SOCIAL SECURITY Department of Health and Mental Hygie Important: If item 27 is marked other tany Injury or other traumatic event, <u>the once.</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STEINBERG BASKIN SAMUEL IDA ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9101 FIELD ROAD - BALTIMORE, RONALD M. STEINBERG / SON MD 21208 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) ARLINGTON CHIZUK
AMUNO CONG
22. Name and Address of Facility 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD 09/12/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosci **Physician** /Medical Due to (or as a consequence of) abetes Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 ☐ Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has birector, page 2 s 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

within 24 hours after death

the Funeral Director:
completely filled in by the 2

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Boulevard, Batting ore, MD. 21218 32. gistrar's Signature 31. Date filed (Month, Day, Year)

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

September 10, 2007

07-06971 Shon Taylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 29412 1- For State Certificate of Death Rea. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Month Day September 8, 2007 0556 hrs Medical Examiner Shon Taylor 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Days Hours. 179-56-7307 Director July 21,1973 Country) 34 1 X M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location PA Allegheny Pittsburgh 1 X Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15235 212 USA Pinewood Square Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XXNever Married 2 Armed Forces' Married Yes 2 X No **Black** If Yes, Give Year Yes 2X No specify: Specify Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 721 is marked other than atic event, the Medical ABM Janitorial Services Janitor 21215-0036 12 should be filed within Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rocky Wallace Yvonne Taylor Reed Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) QM 90 Waverly Drive, Building U Apt. 202, Frederick, Yvonne Taylor Reed / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Mckeesport-Versailles portant: ury or oth 9/14/2007 McKeesport, PA Donation 5 Other Specify: 21. Signature of Euneral Service Licensee Charles L. Stevens Funeral Home I 1501 East Fort Avenue, Baltimore, Home Inc \mathcal{N} vota Approximate Interval 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line. /Medical Death Methadone intoxication Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical the attending physician ed for use as the burial -X UNPENDED #MENDED, 27, 28a-f, perME, C872, 10/1/07 TT the death certificate be Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Year Live birth Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknowr 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy certificate has death? performed? 2 No ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? DOA Nursing Home 5 Other Inpatient 2 V ER/Outpatient 3 Residence 6 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification Natural Yes 2 X No neral Director: 5 Pending Fnd 9/8/2007 unk unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide or Town, State determined (Specify) Homicide empletely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

Assistant Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 8, 2007

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Laron Locke MD. 31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death MARJORIE L. THOMAS SEPT. 6:25A M 08 2007 a Facility Name (If not institution, give street and number) LORIEN COLUMBIA NURSING & REHABILITATION 4b. City, Town, or Location of Death 4c. County of Death COLUMBIA HOWARD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months Days 89 219-18-0016 MARYLAND 5/29/1918 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD ANNE ARUNDEL 1 ☐ Yes 2 No HANOVER 10f. Zip Code 10g. Citizen of What Country? USA 21076 7534 LEMON TREE COURT 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: BLACK 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE'S ASSISTANT MEDICAL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDMONIA HALL BENJAMIN HALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 7534 LEMON TREE COURT, HANOVER, MD 21076 MELVIN THOMAS GRANDSON 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD NATL MEM. PARK 9/14/07 LAUREL, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 Funeral Service Licensee 21. Signature 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD ase, or complications that caused the degral. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death diat Cause (Final s r condition g in death) dul enjestive Due to (or as a consequence of): diseense Stage if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760, attending properties for use as certificate ha after death.

I Director: /
d in by the f within 24 hours a

To the Funeral I

completely filled

Physician

/Medical

Examiner

Funeral

Director

28a-f show be notified

5

ıral", or items 23a o Examiner must be

'natural', or

Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event once.

Physician

/Medical

Director

Funeral

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Completed

Be

Examiner

Medical Certification: To Be Completed by Physician/Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

(our

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome pf pregn 1☐Live birth 2☐Fet 4☐Pregnant at time of o 9☐Unknown	al death 3 □Ectopic	pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	g cause given in Part I.		acco use contribute to the cause of death? s 2₽√No 3□ Probably 4□Unknown
				24a. Was an autopsy perform 1□ Yes 2	prior to completion of cause of
25. Was case referred to medical			26. Place	of Death (Check only one))
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nui	rsing Home 5 Reside	nce 6 □Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ N	28d. Describe ho	w injury occurred
3 Suicide 6 Could not b determined		ome, farm, street, fact	ory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)

State Registrar

1.4300 32. Recentrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 200

CHITW LA

Callas.

29c. License number

DUU53709

1 cm

2007 . 12 Th

29d. Date signed (Month, Day, Year)

Ħ MD 20

VOID

CERTIFICATE #

07-29414

SEE

CERTIFICATE #

Fetal - 07-00857

			for State	State of Mary		artment of F		Mental F			
¥.	Physici	ian	1. Decedent's Name (First, Middle, La	,	00,			2. Date of Month		Day Year	3. Time of Death
	/Medi		Estelle 4a. Facility Name (If not institution, giv	E .		Tayl		Septen		5 200) Ic. County of Death	
ř	Examir	ner		·			more	util		io. County of Boats	
	Funeral		5. Social Security Number 6. S	ex 7. Age (II	n yrs. last birthday)		If Under 24 Hi Hours Mi		Birth Day, Yea	9. Birth	place (State or Foreign
	Director		031-22-4121	□M 3∏F 7	78 Yrs.	Wortins Days	riodis igii	09	07	28	NY
	and aw		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation					10d. Inside City Limits
	Maryl f sho	ō	MD NA		Bal	timore					X □Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. (Citizen of What Cou	
	th wit		3700 Beehler	Ave		2	1215			U.S.A.	
	tems er mi	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-	14. Race - Ameri Black, White	
20	rs afte	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2√ No	Specify:			Specify: F	Black
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คั	s 1 ar f Hea ftem 3		20a. Method of Disposition		20b. Place of Dispo		i	Date		Location - City or T	
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5	nding th. : Afte fune	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury	Worl	k? Yes 2 ∐ No	Zou. Descri	se now in	jury occurred	
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5	tal or s afte al Dir	Certification:	4 Dillomoide	ballaling, etc. (c				City or	Tòwn, Sta	ite)	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of miner: On the basis of example and manner stated	amination and/or in	occurred at the tirvestigation, in my o	ne, date and pla pinion, death oc	ce, and due to curred at the tir	he cause ne, date a	(s) and manner as and place, and due	stated. to the cause(s)
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_				Z MA		D59	062		5.	tember 5	2007
1	/		30. Name and address of person who		(Item 23a) (Type,	Print)				,,	0
		7 91	Chad Hansen, MA 31. Date filed (Month, Day, Year)	32. Flesistrar's	Signature	Baltim	IOTE M.	D 212.	15		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 5:55cLM SepT. Reginald 200) /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 6. Sex Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**/**M 2□F Days Hours Director 05.06. Maryland r 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No hondallsta Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code iral", or items 23a or Examiner must be Harhate Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 □ No 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 'natural', If Item 27 is marked other than "nature or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) condary (0-12) tary/Seco unningham Detirement Army 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Selena 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gastins/Niece Baltimon MD 21216 Rd tairfax hachelle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State En National 4-19-2007 Arlington VA 22. Name and Address of Facility Vaugan C. Green Juniou Serice 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Thondanstan MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Gastro in test-nel Ble /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any property cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last metas he fic Due to or as a conse uence of Examiner Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed' funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **№**6 1 inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dea. ral Director Afr 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ö within 24 hours a To the Funeral (To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29085 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

5310

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 4a, 27, per MD, g871, 9/13/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month WOODEN /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death SPICE GALTIHORE NIA y Xear) 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 216-62-162 Days Min 1 ☐ M 2 K F Director MARVLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ral", or items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 No Directo MARYLAND 10e. Street and Number 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) MAID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WOODEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Racility ULTON AVE 2121 hard. Enter the disease, or complications that caused the death. ship k, or hard failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory a fest, Immediate Cause (Final difference or condition relating in death) Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and physician ar Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 ☐ Yes 2 No 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No rmed? 2 No Vital 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 9 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 2 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lanvale St. Year) State 1 3 SEP Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
APEND TIPW#1, perPHYS. 1871,9713/07, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 1. Decedent's Name (First, Middle, Last) Blanche Wall 2. Date of Death Month **Physician** 5:00 AM 0 /Medical 0% 4a. Facility Name (If not institution, give street and pumber) 4b. City. Town, or Location of Death 4c. County of Death Examiner altimere Hayen MUSSING ome 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 M 2 V Director Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Jown or Location 10d. Inside City Limits 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ation - City or Town State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 21. Signatur uneral Service Ligensee 22. Name and Address of Facility 46001 Heights 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician a les /Medical Due to (or as a consequence of): Examiner nmar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence The law requires that the death certificate be executed and burial-tra P.O. Box 68760, physician Physician/Medical the as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) been signed by the should be detached 9 🔀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No page 2 sl 24a. Was an autopsy performed? Yes 2/10 No After this certificate 10 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2**X** No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Year) 5 Pending investigation To the Hospital or Attendle within 24 hours after death.

To the Funeral Director; Ar completely filled in by the fu death. 1 Tes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 lagem 30. Name and address of person who completed cause of death (Item 23a) (Type_Print) MECM 32. Régistrar s Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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/Medic	al -			waru		4h City Town or	Location of I			10, 2007	6:10 PM M	
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Funeral		5. Social Security Number 6. S		e (In yrs. la:	st birthday)	If Under 1 Year	II If Under 24		th	9. Birth	place (State or Foreign	
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 Certifying Ph	nysician: To the best on iner: On the basis of	examination	ledge, deat on and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time	cause(s , date an	s) and manner as d place, and due	stated. to the cause(s)	
o the o the omple	Med	29b. Signature and title of certifier	and manner sta	nea.		29c. License	number		29d. Da	ite signed (Month	, Day, Year)	
FSFO						174	137	26		9/11/0	7	
~ ~		30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type,	Print)) / 6		_	1/11/01		
Q I		DR. TARIQ MAHMOO					INONI	M, MD 210	93			
Sta		31. Date filed (Month, Day, Year)	36 Degistre	ela Cianatu	uro .							
Registr		SEP 1 3 200	1 Stephen	Jan State	Jag Par							
MH 17 Rev 1/20	JUT											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HARRY LEE WITHROW Sept. 07, 2007 3:15 p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7782 Edgewwod Anne Arundel Avenue Pasadena 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 M 2 □ F Months Hours 233-46-6178 78 Director Dec.30,1928 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. m 27 is marked other than "natural", or Items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Anne Arundel Pasadena 1 ☐Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.A. 7782 Edgewood Avenue Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter's Helper B & O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Withrow Elzora Withrow ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Janie V. Withrow 7782 Edgewood Avenue, Pasadena, Maryland 21122 (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park +09-12-07 Glen Burnie, Maryland 4 Donation 5 Dother (Specify) McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service Licensal 23a. Art1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death prediate Cause (Final sease or condition resulting in death) Carcinalny Atte Kidnex **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23b. Was decedent prognant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only examiner' Other: 4 Nursing Home 1 79s ² 2 No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ■ Residence 6 □ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 290 Date signed (Month, Day, Year)
Sufulen 10, 200

The Company Heshway 6 [cyssworks]
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Mershway 210 6]

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: death within 24 hours a To the Funeral L

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier elun

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month WITZIER September 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore (1If Under 1 Year | If Under 24 Hrs. The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Yea Apr 8, 19 5. Social Security Number V. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Unk Days Hours Months Min. 1**∑**M 2□F 1929 Yrs 213-26-2461 78 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1√Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1508 W. 36th Street 21211 USA 12. Was Decedent Ever in U.Sunk Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk un (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) in 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street censee Westes, 21. Signature of Funeral Service Ronald Baltimore, MD 23a. Part. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autops) perfort Dick To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 npatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 No 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) armois 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Street 600 North arinci 31. Date filed (Month: Day, Year), 32. Begistrar's Signature State Registrar 3 2007 ÖRIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

07-06843 Weeta L. White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 29422

	1- For State Registrar	Certificate of	Death	Reg. No.						
Physician				. Date of Death Month Day Year	3. Time of Death					
ledical Examine	Weeta L. White	*		September 3, 2007	1235 hrs					
	4a. Facility Name (if not institution, give street ar 12904 Stonecrest Drive	d number) 4	b. City, Town, or Location of Death Silver Spring	The state of the s	4c. County of Death Montgomery					
Funeral	Social Security Number	7. Age (In yrs. last birthday)		8. Date of Birth (MM/DD/YYYY)						
Director	237-48-5022 _{1 M 2} X	F 72 Yrs.	Months Days Hours Min.	Jan 19, 1935	Country Carolina					
A COLUMN DE SANS PAGE PRÉDITOR ACCORDANT AND LES SOUR	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	on		10d. Inside City Limits					
* ,	MD Montgomery	Silver	Spring		1 Yes 2 X No					
laryland 28a-f show at once.	10e. Street and Number	BIIVEI	10f. Zip Code	10g. Citizen of What	t Country?					
the Natified	_ I	e	20904	USA						
with ms 2.	11. Marital Status		Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto R		American Indian, Black, *					
r death with or items 23	1 Never Married 2 Married 1	es 2 X No								
safter rall.,	or Dates:		Yes 2 X No specify:	Specify:	white					
"natural", Examiner	15. Decedent's Education (Specify only highes	dunna ma	's Usual Occupation (Give kind of wo ost of working life. DO NOT use retire		ness/industry					
within 72 hours giene. The than "natu Medical Examples of the control of the cont	Elementary/Secondary (0-12) Coile	ge (1-4 or 5+)		THAT						
5-0036 fled within 72 Hygiene. to ther than "	12 4	techni	ical writer	JHAPL First, Middle, Maiden Surname)	1-					
1	17. Father's Name (First, Middle, East)		unk 18.Mother's Name (Thou, Madelo, Maldon Gariano,	unk					
2121 2121 Mental I Marked ic event,	19a. Informant's Name/Relationship (Type, Print	19b Mailing	Address.: (Street and Number or Ru	ral Route Number, City or Town.	State, Zip Code)					
nore, MD 21 ages 1 and 2 shoulds to Health and Me t: If item 27 is may other traumatic ev	Cornelia Carlisle/fr		Hopi Court Westm		1					
e, MD 1 and 2 sho Health and item 27 is	20a. Method of Disposition	20b. Place of Disposi	tion (Name of cemetery,		City or Town, State					
Baltimore, permit, Pages I am Department of Hea Important: If iten injury or other tra	1 Burial 2 Cremation 3 Remo	val from State crematory or oth	er place)							
Fag thent	4 X Donatton 5 Other Specify:	<u> </u>	Address of Facility							
Balt permit. Departi Impor	21. Signature of Funeral Service Licen	Director 22S	ame and Address of Facility Late Anatomy Boar	d 655 W. Baltin	nore Street					
	23a Det I Enter the disease of complications to	hat caused the death. Do not enter th	altimore, MD 212	01	t Approximate Interval					
Physician Medical	failure. List only one cause on each line.	failure. List only one cause on each line. Between Onset and								
caminer		ensive Atherosclerotic Cardi	ovascular Disease		5000					
	Due to (o	r as a consequence of):	77							
3	Sequentially list-conditions, if any, leading to immediate Due to (o	r as a consequence of):	7/ 3/3' . (wing	771						
-	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated									
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	r as a consequence of):								
ecuted and transit				-						
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ox 68 ath certif	past 12 months?	Drognant at time of dooth	tal death 3 Ectopic pregnar her (Specify)	Wichten	Day Tool					
Box 68	1 Yes 2 No 9 V Unknown g									
O. B. at the d d by the etached		ting to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco use contrib	oute to the cause of death?					
P.C	Ág			1 Yes 2 No 3	Probably 4 🗸 Unknown					
w require					ere autopsy findings available					
law r has b					ior to completion of cause of eath?					
Rec The icate	[5]				✓ Yes 2 No					
tal Rec	25. Was case referred to medical examiner?		26.Place of Death (Check of Other)		lou o					
Division of Vital Records, tal or Attending Physician: The law requirnts after dearth. The Director: After this certificate has been sited in by the funeral director, page 2 should be after the control of the contro	O 1 ✓ Yes 2 No	Inpatient 2 ER/Outpatient	•	Home 5 Residence 6 ✓ 28d. Describe how injury occurre						
ing Ph		Date of Injury 28b. Time of I (Month, Day, Year)	1 Yes 2 No	28d. Describe now injury occurre	au .					
ttend death death y the	2 Accident investigation	. Place of Injury - At home, farm, stree								
ivis lor At after d Direct	3 Suicide 6 Could not be 28e	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the	4 Homicide determined (Sp	ecify)	1		- 5					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	one) 2 Medical Examiner: On the l	ne best of my knowledge, death occur pasis of examination and/or investigat	red at the time, date and place, and tion, in my opinion, death occurred at	due to the cause(s) and manner t the time, date and place, and du	as stated. ue to the cause(s)					
To To con	29b. Signature and title of certifier	nner stated.	29c. License number	29d. Date signe	29d. Date signed (Month, Day, Year)					
	MADTZ		O.C.M.E.	September	September 4, 2007					
	30. Name and address of person who complete	30. Name and address of person who completed cause of death (Item 23a)								
		Ana Rubio MDAssistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
Sta		32. Registrar's Signature	9							
Registra	SED (5 /1111 /	Blauer & Par	ash I							

State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signature

Margarita Korell MD.

SEP 1

31. Date filed (Month, Day, Year)

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend State of Mary Rand / Best ment of Health and Mental Hygiene 2007

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) РМ WIENER SEPTEMBER 10 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) MONTGOMERY BETHESDA SUBURBAN HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/02/1924 9. Birthplace (State or Foreign Country) POLAND 7. Age (In yrs. last birthday) 83 153-36-4258 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ¥Yes 2 □ No MONTGOMERY CHEVY CHASE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 4450 SOUTH PARK AVENUE #1107 20815 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married WHITE 1 □ Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 HOUSEWIFE OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **ROSENBLOOM** unknown UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Bural Boute Number, City or Town, State, Zip Code) 1919 EL FREDA ROAD -TEMPLE, AZ. 85284 HARVEY WIENER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) **EWING CEMETERY** 09/12/2007 EWING, NJ. 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STROKE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🕱 No Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? AMIONDARONE LUNG TOXICITY 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

/Medical **Examiner** 0 Records, Vital 9 Division To the Hospital or Attendi within 24 hours are death To the Funeral Director: A completely filled in by the f.

NILL

Physician

/Medical

Éxaminer

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

the Medical

Physician

Director

Completed by Funeral

Be

Physician/Medical

Completed by

To Be

Certification:

Medical

MD

State

Registrar

D26259

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

SEPTEMBER 11, 2007

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

AVA KAUFMAN, MD. - 8218 WISCONSIN AVENUE BETHESDA, MD

SEP 1 2 2007

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)



ORIGINAL

DHMH 17 Nev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#2.perFHYS..Q8/1.9/21/07.WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 Certificate of Death 2. Date of Death Month **II** Day Sept. 10, 2007 1. Decedent's Name (First, Middle, Last) **Physician** NAOMI MADELINE YOUNG 13:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore-Washington Med. Center Glen Burnie 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2**M**F Months Yrs. Feb. 07, 1925 82 Pennsylvania Director 211-18-0956 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at Anne Arundel Maryland Pasadena 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or U.S.A. 259 Harlem Road 21122 "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural" or itel 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 21215-0036 1 ☐ Yes 2 No Specify Specify: Completed by 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Schoff George Evans Pear1 ို traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 259 Harlem Road, Pasadena, Maryland 21122 Laura Young-Nickey (Daughter) item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville VA Cem. 09-14-07 Crownsville, Maryland 4 □ Donation 5 □ Other (Specify) McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death But 1. Enter the disease, or compile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, check, or heart failure. List only one cause on each line. mediate Cause (Final Physician ANEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed MYDCARDIAL INFARCTION nding physician and use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atter for u in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No page this certificate or Vital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Division 1 Matural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. , ASST. MEDICAL DIRECTOL SEPTEMBER. 12 2007 70061331 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL DRING 6500 BURNIE, MARYLAND 21061 NEEL VIBHAKAE, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ABDEL-SHAHEED 8 \bigcirc 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MD. HOSPICE AT THE LAKE COASTAL WICOMICO SALIS BURY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days JAN 9, 195-48-3534 Egypt Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b, County 1 ☐ Yes 2 No Director Virginia Wicomico Sterling 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 20819 Blossom Landing Way 20165 United States r than "natural", or items 23a the Medical Examiner must be Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Accountant</u> World Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be item 27 is marked other traumatic e Faheem Abdel-Shaheem Elizabeth Abdel-Shaheed 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i 20819 Blossom Landing Way, Sterling, VA 20165 et of Disposition (Name of Date 20c. Location - City or Town, State Bassem Girgis / Son-in-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If iter
any injury or ott 1 XBurial 2 Cremation 3 Removal from State Fairfax Memorial 4 ☐ Donation 5 ☐ Other (Specify) 8/31/2007 Fairfax, Virginia 22. Name and Address of Facility
Fairfax Memorial Funeral Home 21. Signature of Funeral Service Licensee in Mc Per MO1508 9902 Braddock Rd., Fairfax, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cardie on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ole Physician disease or condition resulting in death) /Medical Due to r as a cons quence of): **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an has 3.2 s autopsy page perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27, Manner of Death 28c. Injury at Work? Certification: or Attending 5 Pending investigation 12 Natural after death.

Director: Aff
in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral D completely filled i Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

P.O.

or Vital

State Registra

31. Date filed (Month, Day, Year) AUG 2 9 2007

(Check only

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

08-26-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kebeh Ef	ua Akwa		- For State	State	of Maryland	/ Depart	tment of H <i>ficate of D</i>	ealth an e <i>ath</i>	id Mental		g. No. 20	07 2	942
Р	hysicia	F	tenistrar	e (First, Middle,Las	t)	00717	modito or E	-		2. Date of Death	1	3. Time of De	
Medical		ner			E. AKWAF					Month August 26,	2007	0908 hr	S
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea Suburban Hospital Bethesda						eath	th 4c. County of Death Montgomery			
Fu	uneral		5. Social Security N		ex 7. A	ge (In yrs. las		f Under 1 Ye			h(MM/DD/YYYY) 9. For	Birthplace (State	or
	rector		219-98-	4838 1	M 2X F	26	Yrs.	Months Day	ys Hours	Aug.		CouWash.	, DC
	any	_	Usual Residence o 10a. State	f Decedent 10b. County		10c. City, T	own or Location				10d. Inside City Limit		
2	≥		MD	Pr. G	eorges		Laurel 10f. Zip Code					1 X Yes 2 No	
Aarylar	28a-f s	Director	10e. Street and Nu	mber						.10	og. Citizen of What C		
h the N	23a or 28a-f show notified at once.			Londond	erry Cou		13 Wro D		20707	(Specify Yes or No	U.S.Z	nerican Indian, B	Black,
Baltimore, MD 21215-0036	items 2	Funeral	 Marital Status Never Marri 	ied 2 Married	12. Was Deceder Armed Forces	?				uerto Rican, etc.)	White, etc		
ifter de	ıl", or ner mı	by Fu	3 Widowed	4 Divorced	1 Yes If Yes, Give Year or Dates:	² X No		es 2X N			Specify:	Black	
hours	nature Exami	ed b			only highest grade co		16a. Decedent's during most	Usual Occup of working lit	ation (Give kind fe. DO NOT use	d of work done e retired)	16b. Kind of Busine Washine		
36 hin 72	than "	Completed	Elementary/Sec 12th	ondary (0-12)	College (1-4 o	3+)	Medic	al Te	chnic:		Adventi		g
5-00 ed with	lygien other the Mo			(First, Middle, Last						Name (First, Middle, I			
121 dbe fil	dental Hygiene, "natural", narked other than "natural", event, the Medical Examiner	Be		eter Akv		-	19b. Mailing A	ddress (Str	eet and Numbe	ances Br	nber, City or Town, S	ate, Zip Code),	742
1D 2	fealth and N tem 27 is in traumatic	2			nt (Sist	er)	28 Pe	pper	Mill I	Dr, Capi	tol Heig	ıhts,Mİ)
. je	Health Fitem		20a. Method of Dis		Removal from S		lace of Disposition		cemetery,	Date	20c. Location - City	or Town, State	
mol	ment of F tant: If i		4 Donation 5	5 Other Specific	v: _ /	Gat					Silver		
3alti	Departr Import		21. Sign tire of F	uneral Service Lice	LIMIN	Dan					UNERAL E Rockvill		
	/sician	- 1	23a. Part I. Enter	the disease, or com	plications that cause	ed the death.				diac or respiratory arr		Approxim	ate Interval Onset and
"	aminer	S 74	failure. List only one cause on each line. Immediate Cause (Final disease and Multiple Injuries and Multiple										
7 ,	allillei		or condition resulting in death) Due to (or as a consequence of):										
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause										
		Examine	(Disease or injury events resulting in	that initiated	Due to (or as a cor	nsequence of):						
100	s be executed sician and burial - transit	al E	d.										
o -		edical	UNPENDE	D	X AMENDED ME			-			23d. Date of del	ivery	
9289	ing phy as the	sician/M	IF FEMALE: 23b. Was deceder past 12 montl	nt pregnant in the	1 Live birth		2 Fetal	death	3 Ectopic p	pregnancy	Month	Day	Year
Box 6876	earn ce attend for use	sicia		No 9 🗸 Unknow	7	at time of dea	ath 5 Othe	r (Specify)			1		
о В	he law requires that the death certificate ate has been signed by the attending phy age 2 should be detached for use as the	, Phy	Part II. Other sig	nificant conditions	s contributing to de		esulting in the unc	derlying caus	se given in Part		tobacco use contribut		
, P.O.	ires tha i signec d be de	ed by	V							1 Ye		Probably 4	Unknown
of Vital Records,	hysician: The law requi this certificate has been al director, page 2 should	Completed								auto	opsy prio ormed? dea	r to completion on the completion of the complet	of cause of
<u>α</u> ,		E S			T			26 DI	ace of Death (C		2 No 1	Yes 2	No
ita :	ling Physician: The After this certificate funeral director, page	æ	25. Was case reference examiner?		Hospital: 1 Inpa	atient 2	ER/Outpatient		000	Nursing Home 5	Residence 6	Other: Scene	
of C	ing Phy: After thi funeral d	۲.	1 Yes 27. Manner of De	2 No ath	28a. Date of	Injury	28b. Time of Inj		Injury at Work?	Passenger	how injury occurred auto rollover co	Ilision	
ion	ttendin leath. tor: A / the fu	ation	1 Natural 2 ✓ Accident	5 Pending	ation		0430 hrs		Yes 2 V	NO	(Street and Number		Jumher City
Division	after of Direct of in by	Certification:	3 Suicide	6 Could n	ot be 28e. Place o		ome, farm, street	, factory, offic	ce building, etc.	or Town			
b -	To the Hospital or Attending Physicians: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,		29a. Certifier (Check only	Cortifying Phys	ician: To the hest o	f my knowled	ge, death occurre	ed at the time	e, date and place	e, and due to the car	use(s) and manner as	stated.	
	To the within To the comple	Medical		7	ner: On the basis of e and manner state	examination a ed	ind/or investigation		ense number		e and place, and due		
	30	2	29b Signature at	nd title of cectifier	- Par	00.2			C.M.E.		August 27, 2		
	_			dress of person wh	no completed cause	of death (Item		111 Penn	Street, Bal	timore, MD 212	01		
التنوي	S	State			32 Regi:	strar's Signat		M. s					
	Regi		F	100 40 2	.our Jacob	we t	AFRICA			<u>. </u>			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For L State Registrar	State of	Maryland / De	epartment of I Dertificate of			giene 007	29428	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death								
	Physici		Γ								
	/Medic Examin										
	LAGITIII	C1	Laurelwood Nurs	ing and l	Rehahilitat	ion F11	kton		Ceci1		
	Funeral				. Age (In yrs. last birth	tay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		thplace (State or Foreign	
	Director		240-22-0884	1 □ M 2 X IXF	93 Yr	s. Months Days	Hours Min.	March 1		ountry) rginia	
			Usual Residence of Decedent					IRICH I	, 1)1- VI	- GIIII-G	
	ylan		10a. State 10b. County		10c. City, Town of	r Location				10d. Inside City Limits	
	Marie S	į	Maryland Cecil		E1ktor	1				1 X Yes 2 No	
	r 28	ire	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Co	ountry?	
	h wit	<u>e</u>	48 Hollingsworth	Manor Ro	oad	2192			United Sta	tes	
	deat	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	erican Indian,	
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any nitury or other traumatic event, I've Modical Examinations to intilling at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give	ΣVο	1 ☐ Yes 2 ☑ No	an, Mexican, Puèrto Specify:	Hican, etc.)	Black, White		
21215-0036	tural	b b	15. Decedent's	Year or Dat		prodontia Hauat Ossu	nation		16h Kind of Business	(Industry)	
5	"nai	Completed	(Specify only highest g		(0	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	during most of work	ring	16b. Kind of Business	rindustry	
12	within lene. than "	E	Elementary/Secondary (0-12)	College (1-4	for 5+)						
	Hygir Hygir Ther nt, II		17. Father's Name (First, Middle, Lat	st)		lomemaker	18 Mother's Nam	e (First Middle	Own Home Maiden Sumame)		
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "Irammatic event, Iram."	To Be	John McCraw	,				Johnson	maidon odmamo,		
<u></u>	shoul nd Me mari	F	19a. Informant's Name/Relationship	(Type, Print)	19b. N	failing Address (Stree			r, City or Town, State,	Zip Code)	
S	id 2 ::		Donna Thomas / D			ottingham				·	
	1 ar Hea tem 3		20a. Method of Disposition		20b. Place of D	isposition (Name of		Date	20c. Location - City or		
Baltimore,	ages ont of t: If I		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ate	crematory or other pla	_	cember	Ob a server III 1	1 M11	
⋣	it. P		21. Signature of Funeral Service Lig		Cherry	Hill Cemet				l, Maryland	
Ba	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any njury or other trai		VIIIIAA.C	ul						aryland21901	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co	mplica ins that cau	sed the death. Do no	enter the mode of dy	ng, such as cardiac	or respiratory arr	rest,	Approximate	
			shock, or heart failure. List only one cause on each line.								
			Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):								
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		ē	Sequentially list conditions, They leading them siles. Due to for as a consequence of:							Con it is	
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89	ticate p phy is the			u.							
Вох	nding use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy	_			23d. Date of de	livery	
ă	atte	ciai	in the past 12 months?		h 2 □Fetal death nt at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	У		Month	Day Year	
P.O.	that the de ed by the detached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow	m						
	that the	4	Part II. Other significant conditions	contributing to dea	th but not resulting in th	ne underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
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00	w requir been si should	lete						24a. Was a	an 24b. Were a	utopsy findings available	
Re	he lav	Completed			· · · · · ·			autops	sy prior to death?	completion of cause of	
ल	ding Physician: The n. After this certificate hat tuneral director, page	e Cc	OS Was seen referred to medical						2☑No 1□Yes	21 No	
Ξ	Physician: r this certitica ral director, p	o Be	25. Was case referred to medical examiner?	Hospital:		Ot	ner -	th (Check only or			
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O	ding F h. After tunera	tion	1 □Natural 5 □ Pending	28a. Bate of (Month,	Day Year) Inju	ry Wo	rk? Yes 2 □ No		on any observed		
Si	deatl	Ca	3 ☐ Suicide 6 ☐ Could not	be Re Place	f Injury - At home, farm		,100 20.10	28f Location (S	treet and Number or R	ura I Route Number	
Division	I or Attendi after death. Director: A i in by the tu	Certification;	4 Homicide determine	building	, etc. (Specily)	, street, ractory, office		City or Town		Biar i route Hamber,	
_	spita ours ieral tilled		29a. Certifier Certifying I	hysidian: To the h	est of parknowladne	aath Janung Cat King	nes data and class	and disc to the w	auso(s) and marmor as	s state č.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely tilled in by the tune	Medical	(Check only one)	mner: On the bas	is of examination and/	or investigation, in my	opinion, death occur	red at the time, d	late and place, and du	o to the cause(s)	
	To th withir To th	Me	29b. Signature and title of certifie	11/		29c. Licen	_	2	29d. Date signed (Mont	h, Day, Year)	
)) H	1/ton.		_ 05	1073		30 AU60	7	
			30. Name and address of perion wh	pleted cause	of death (Item 23a) (Ty						
			ARUSY STONE	ND 8	of death (Item 23a) (Ty Cth2Ct pistrar's Signature	AMUS ()	2 No	, CASTIF	DE 197	20	
							- / / / /	12100	- 11		
	Sta	te	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signature	1. 11.0	4				

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend steen of Margiand 90 &871 ment of 1972 all the and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 31,2007 Joseph Amato August 4:30A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1713 Chrisara Court

5. Social Security Number | 6. Sex | 7 Forest Hill Harford Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Davs Hours 1 XM 2 ☐ F Months Director 087-12-8713 March 8,1921 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 No Maryland Harford Forest Hill 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21050 U.S.A. 1713 Chrisara Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: þ Specify: White 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Elevator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Thomas Amato Helen McAvoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1713 Chrisara Court Forest Hill Maryland ce of Disposition (Name of Date 20c. Location - City or Town, State Joseph Amato /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rosedale Cemetery 9-1-07 Linden, New Jersey 22. Name and Address of Facility
Marzullo Funeral Chapel, P.A.
5009 Harford Road Baltimore, Maryland21214 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) DISSOCIATION ELECTRO MECHANICAL /Medical Due to (or as a consequence of): HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine PLUMONARY DISGASE CHRONIC OBCIRUCTURE Due to (or as a consequence of): physician CHRONIC Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Otheg ^oL 1 ☐ Yes vursing Home 5 XResidence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? I Director: After to d in by the funera 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 Accident 6 Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26191 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIVE, SUITE 21/22B, BELAIR, MD 21014

Do. ANUSITA . SIRITHARA, 260 CATEWAY DRIVE, SUITE 21/22B, BELAIR, MD 21014

State Registrar

31. Date filed (Month, Day, Year) **SEP 13** 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death **Physician** ANKSTON MALE 1322 25 0 /Medical 4c. County of Death 4a. Faqility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE CHEVERLY HOSPITAL CENTER GEORGE'S GEORGE'S PRINCE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day 04 - 24 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ★ M 2 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at PRINCE GEORGE'S HYATTSVILLE, 1 XYes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number VILLAGE by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No BLACK Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) INFANT INFANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WKNOWN BANKSTON DANISHA ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREEN DR HYATTSVILLE, MD MOTHER 1790 VILLAGE DANISHA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 🕱 Other (Specify) RELEASE To HOSP 5-1-01 CHEVERLY, MD 21. Signature of Funeral Service Licensee 3001 HOSPITAL 20785 SHEVERLY, 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DYNDROME DISTRESS **Physician** /Medical Due to (or as a consequence of) Examiner TREMATUR 17 REME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the hiria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tyes 2XNo 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an certificate has birector, page 2 s Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 727628

DHMH 17 Rev 1/2001

State Registrar 3001

HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JA ISABEITA G.

31. Date filed (Month, Day, Year)

SEP 1 3 2007

FRATTAROLA

32. Registrar's Signature

7-06924 Austin Butler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day September 6, 2007 hysician/ 0106 hrs Butler Webster Examiner Austin 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury Peninsula Regional Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs, last birthday) 5. Social Security Number **Funeral** Foreign Min. Months Days Hours, 11/19/1987 Country) Maryland 19 Director 214-19-1210 1 X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State Yes 2 X No Princess Anne MD Somerset or 28a-f show 23a or 28a-f show notified at once. Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 11130 Stewart Neck Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Mantal Status must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) .White, etc. Armed Forces? 1 Never Married · 2 Specify: White Yes If Yes, Give Year 1 Yes 2 No specify: Divorced Widowed ş 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) ges 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.

If item 27 is marked other than "natur they traumatic event, the Medical Exami during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 College Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rebecca F. Miller Be Joseph Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 11130 Stewart Neck Road, Princess Anne, MD 21853 Rebecca Miller 20c. Location ~ City or Town, State 20b. Place of Disposition (Name of cemetery, int. Pages 1 a...
Jepartment of Healthportant: If injury or o' 20a, Method of Disposition timore, crematory or other place) Burial 2 Cremation 3 Removal from State 9/7/2007 Salisbury, Maryland Salisbury Crematory Other Specify: Donation 5 22 Name and Address of Facility Hinman Funeral Home . Signature of Faheral Service Licensee 21853 Princess M00295 11673 Somerset Ave.. <u>Anne</u> Approximate Interval 23a. Part I. Enter the disease, or complications pat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and /sician failure. List only one cause on each line. Death Medical a. Methadone intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 27,28a-f, X UNPENDED perME, g872, 10/2/07 TT attending physician or use as the burial 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o 1 Yes 2 No 3 Probably 4 Unknown þ σ. Completed 24b. Were autopsy findings available Records, 24a. Was an prior to completion of cause of autopsy performed certificate has 2 No 1 V Yes ✓ Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical of Vital Be Other₄ examiner? Hospital: Nursing Home 5 Residence 6 Other: DOA Inpatient 2 V ER/Outpatient 3 After this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification 1 Yes 2 X No Natural Division Pending FNd 9/5/2007 Fnd 10:30pm the Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc in by 6 X Could not be or Town, State) MD 11130 Stewart Neck Rd. Princess Anne Suicide determined (Specify) within 24 hours a To the Funeral I Found: residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 6, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner

31. Date filed (Month, Day, Year)

State Registrar

ORIGINAL

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HAZEL BISHOP 2007 2:40 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 X F 226-07-3312 89 Director 05/06/1918 VA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 X Yes 2 □ No MD Frederick Funeral Director Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5957 Quinn Orchard Road 21704 US Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Specify: δ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ed other than "event, the Med College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental 27 is marked c Ruby Katherine Kaylor James Earl Ellington 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Solitude Trail, Berkeley Springs, WV 25411 19a. Informant's Name/Relationship (Type, Print) Earle B. Meek / Daughter f Health a Item 27 is other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 08/30/2007 4 Donation 5 Other (Specify) Smithsburg, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ulmonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours af

To the Funerat D

completely filled i Medical 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3H-15

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State

Registrar

29b. Signatule and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 0 4 2007

Hemen Shah, 65C Thomas Johnson Drive, Frederick, MD 21702 32. Registrar's Signature

29c. License number

D006041

29d. Date signed (Month, Day, Year)

8-29-2007

State of Maryland / Department of Health and Mental Hygiene, 29434 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2007 26, 10:48 a August Robert William Burke, III /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Prince Frederick <u>Calvert Memorial Hospital</u> Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Unde Hours 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days 1 ₹M 2 □ F 46 12/7/1960 D.C Director 577-96-3915 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County r 28a-f show notified at 1XXYes 2 □ No Director Prince Frederick MD Calvert 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be re USA 110 Alton Court #221 20678 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White à 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Plumbing Company Plumber 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ith and Mental F. Edith Joan Collins Robert William Burke, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau 9703 Rosaryville Road, Upper Marlboro, Theresa Webster/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/28/2007 Beltsville, MD Chesapeake Crem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Raymond-Wood F.H., P.A. 000 PO Box 430, Dunkirk, MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In farction Immediate Cause (Final 40 cardia hr Physician disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading Universal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death
9☐Unknown in the past 12 months? 5 Other (specify) 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1☐ Yes 2☐ Yo 3□ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Injury ↑ Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: A 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Funeral I **Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8/27/07 raron 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd, Suite 117, Annapolis, MD 21401 2629 Riva NESSI 32. Registra/s Signature 31. Date filed (Month, Day, Year) State AUG 2 8 2007▶ Registrar

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar		Certi	ificate of L	Death		Reg. No.						
9.50	Decedent's Name (First, Middle, Last)					2. Date of D	eath Day	Year	3. Time of Deat				
ian cal	BARBARA	S. BIDERM	AN			AUG.	26,	2007	8:32 A				
	4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of D	eath	4c. C	County of Death					
	SUBURBAN HOSPITAL			BETH				MONTGOM					
	5. Social Security Number 6. Sex 1	7. Age (In yrs. last		If Under 1 Year Months Days		Hrs. 8. Date of E (Month, I JULY	lirth Day, Year) L, 193	9. Birth Cou	place (State or For intry) AHOMA				
1 -	Usual Residence of Decedent 10a. State 10b. County	10c. City,					10d. Inside City Lin						
Director	MD. MONTGOMERY 10e. Street and Number			BETHESD 10f. Zip Code	Α		10a. Citiz	Citizen of What Country?					
흐				208	1.4			U.S.A.	,				
Funeral		as Decedent Ever in U.S.	. 13. Wa	as Decedent of Hi	spanic Origin	No- 1	4. Race - Amer						
To Be Completed by Funeral Director	1 Never Married 2 X Married 1 [med Forces? □Yes 2▼ No Yes, Give ear or Dates:		Yes 2. No	n, мехісап, Р Specify:	uèrto Rican, etc.)		Black, White, etc. Specify: WHITE					
ompleted	15. Decedent's Education (Specify only highest grade com,	pieted)	(Give ki	nt's Usual Occupa nd of work done of NOT use retired	furing most of	working	16b. Kin	d of Business/li	ndustry				
Eo	Elementary/Secondary (0-12)	ollege (1-4or 5+)		SECRETA	RY		S	ECRETAR	RIAL				
O .	17. Father's Name (First, Middle, Last)					Name (First, Midd	le, Maiden S	Surname)					
o.	SAM	DIAMOND				ESTHER -	н	RSKAWIT	Z				
۳.	19a. Informant's Name/Relationship (Type, Pr	rint)	19b. Mailing	Address (Street a	and Number o	r Rural Route Nun	ber, City or	Town, State, Zi	ip Code)				
	BENJAMIN BIDERMAN/	HUSBAND	6049	ROSSMORE	DR.,	BETHESDA	MD.	20814					
	20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	val from State		tion (Name of tory or other place		Date 28-2007		ERDALE,					
	21. Signature of Funeral Service Licensee	1. 0	22. CH.	Name and Addres	s of Facility	HOME & C	CREMAT	ORIUM, E	P.A.				
	23a. Part1. Enter the disease, or complication					VE., RIVI		, MD. 2	Approximate				
	shock, or heart failure. List only one call	e on each line.			9, 000	,			Interval Betwee Onset and Deat				
	disease or condition a. U	ROSEPSIS							THE STATE OF THE S				
al· er		Due to (or as a conseque EIZURE	ence or):										
ē	if any leading to immediate	Due to (or as a conseque	ence of):	-									
Examine	cause. Enter Underlying Causa (Disease or injury that initiated events c. F	EVER											
Еха	resulting in death) Last Due to (or as a consequence of):												
edical	d. ALZHEIMER'S DISEASE												
hyslclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	2	23d. Date of delivery Month Day Year										
0	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?												
d by	HYPERTENSION					1[∃Yes 2[No 3□Pro	obabiy 4 X Unkr				
pleted						pe	topsy rformed?	prior to death?	topsy findings ava- completion of cause				
E	1 Yes 2 No												
e Compl	25. Was case referred to medical examiner? 46. Place of Death (Check only one)												
o Be Com	examiner? Hospit	al: 177 Inpatient 2 □ F	1 Yes 2 No rospital: 1 Inpatient 2 ER/Outpatient 3 DOA rospital: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Park 19a. Year) 28b. Time of Park 19a. Year) 28c. Injury at 28d. Describe how injury occurred Work?										
To Be	examiner? 1	Ba. Date of Injury	28b. Time of	28c. Injur	y at	28d. Describ		ccurred					
To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation	Ba. Date of Injury	28b. Time of Injury	28c. Injur Wor M 1	y at k?	28d. Describ	e how injury	d Number or Ru	ral Route Number,				
Certification: To Be	examiner? 1 Yes 2 No Hospit 27. Manner of Death 1 XNatural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Examiner: C	Be. Place of Injury - At hor building, etc. (Specify)	28b. Time of Injury me, farm, stree)	28c. Injun Wor M 1 =	y at k? Yes 2 No	28d. Describ	e how injury (Street and Fown, State)	d Number or Ru and manner as	ral Route Number, stated. to the cause(s)				
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State of Maryland / Department of Health and Mental Hygiene 0/5/07. DES.MCO Certificate of Death Reg. No. 2007 1 - State Registra MEND#17, perFH, 9/5/07, DPS, MoCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 27, 2007 0045 Claudia H. Borthwick Aug. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2X F Yrs 3, 1914 S.C. 92 Director Sept. 248-01-1724 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1XIYes 2□No Director D.C. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4901 Connecticut Ave. N.W. # 203 20008 U.S.A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 12 No If Yes, Give Year or Dates: 1 Never Married 2 Married Borthwick, Claudia Chreet Setles of the Setles Setles of Setles Setles of Se 1 ☐ Yes 2 🖾 No þ Specify: 2 should be filed within 72 hours a and Mental Hygiene.

Is marked other than "natural", o 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Communication Elementary/Secondary (0-12) College (1-4or 5+) 12 Management Analyst Commission 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James A. Borthwick James Perry Hammond Mary Ola Putnam ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Patricia A. Borthwick-daughter 3100 Connecticut Ave. N.W. #435 Wash. D.C. 20008 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any injury or ot once, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 29,07 Falls Church, Va. National Crematory 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licens 5130 Wisconsin Ave. N.W. Wash. D.C. 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** heart month /Medical Due to (or as a consequence of): Examiner difficile C. weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s 2**X** No 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Medical Certification: To this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No ours after death.
neral Director: Al 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0066003 Xelinationer , M. D. 27,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helina Kassahun, MD 8600 Old Georgetown Rd Bethesda, Maryland 20814 gistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 07-06535 Preston Eric Blalock, IIII

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and one one one one one one one one one one	Certifying Ph	hysician: To the beaminer:On the basis	est of my knowle	edge, death	occurred at the	e time, date and	place, and due	to the cause time, date a	(s) and manne nd place, and	ir as stated. due to the ci	ause(s)	
29b. Signature		and manner s	s of examination stated.	n and/or inve					29d. Date sign	ned (Month.	, Day, Year)	
[13]	and title of certifie	er			29	c. License numb	101	ł	August 25		,,	
- Works	gutt Dr	re Krell	Q			O.C.M.E.			, lugust 20	,		
30. Name and a	address of person	who completed cau	use of death (Ite	tem 23a)		Delite	oro MD 040	01				
	a Korell MD.		edical Exam	niner 11	1 Penn St	treet, Baltim	ore, MD 212	υI				
State 31. Date filed (A	Month, Day, Year)	Assistant Me										

ORIGINAL

Certificate of Death

29438

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 27, 6:07 рм BATTLE 2007 LILLIAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X X 19 1943 242-70-4202 N.C. Director 63 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 X Yes 2 ☐ No Washington D.C. Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20002 United States 1717 Μ St., N.E. Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: ş 3 ☐ Widowed 4 X Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Government 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth eny injury or other traumatic event 2008. Be Mary Jones Lency Lee Bell 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wash., DC 20019 778 Kenilworth Terrace, NE Rose L.B. Boykins / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 4 ☐ Donation, 5 ☐ Other (Specify) Chesapeake Crematory 8-29-07 Beltsville, Md. 21. Signature of Juneral Service License 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002 23a. Part1 Enter the disease, or complished, or heart failure. List on you ations that caused the death. Do not not rethe mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIOPULMONAR-Physician /Medical Due to (or as a consequence of): Examiner ASTROPATESTIMAL BLEEDING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the deeth certificate be executed MYDCAR Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Year Month Day 4 Pregnant at time of death ed by the 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 18ERIEMSION 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 Yes 2⊠ No 2 🗷 No 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifice : After this certification of funeral director. Be 25. Was case referred to medical 26. Place of Death / Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 73257 HOSOVER FARKWAY GREETERS MARYLAND MEJIARA 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

2007

SEP 13

			riease	Type or Print in E			•		
			1 = For State Registrar	State of Marylan		ent of Health and Cate of Death	d Mental Hygien Reg. N	7 11 11 1	29439
ı	Physici	an	Decedent's Name (First, Middle, Last	st)	.2		2. Date of Death	ay Year	3. Time of Death
	/Media	cal	Kosie	Lee	Corr		8-27	7-07	9:00 PM
	Examir	ner	4a. Facility Name (If not institution, give	4	4b.	City, Town, or Location of De	1	c. County of Death Dorche	c.L.,
	Funeral		5. Social Security Number 6. S		Mor	nder 1 Year If Under 24 F		9. Birtho	lace (State or Foreign
	Director		Usual Residence of Decedent	UM 2007	Yrs.		Apr. 117	1908 Vir	ginia
	ryland how		10a. State 10b. County	10c. Cit	y, Town or Location			1	0d. Inside City Limits
	Be-f.	Director	MD Dorci	nester (ambr	idge			1 Pres 2 □ No
)	death with the Maryland oms 23s or 28e-f ehow if inthit by rodiffed at		10e. Street and Number	161. T.	10	7 // / 2	10g. C	itizen of What Cour	ntry?
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2-003	요 크림	ed b	3 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:	16a. Decedent's	Usuaf Occupation	16h	Kind of Business/In	CK
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and	a la de	To Be	John	Matar		N. MOLTHER'S		h' to	
Mary	2 should and Men le marke aumatic	_	19a. Informant's Name/Relationship (7	ypa, Print)	19b. Mailing Add	ress (Street and Number or		or Town, State, Zip	Code)
_	1 and 1 Health Im 27 ther tr		Audrey Gr	eorge land	4219K	idge Crest		MD. 2	1643
ב פ	Pages nent of P nt: If Its iry or of		20a. Method of Disposition 1 ID Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Tigilloval floir State [,	lace of Disposition emetery, crematory	. 1 /3	1 1 ~~	Location - City or To	wn, State
Baltimore,	교투원급 .		21. Signature of Funeral Service Licen			-	11/01 Ca	mbrid	e, ND.
n	Derm Depe Impo eny II		Janelle C	. Henry	Hen	e and Address of Facility RY FUNERUM Washingto	HOME, P. A	ibridge	MD.21613
			23a. Panty Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	dications that caused the beath one cause on each fine.	. Do not enter the	mode of dying, such as card	iac or respiratory arrest,	- 0	Approximate Interval Between Onset and Death
,	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ	losel	rate !	Heet be	seese	
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ī	led sit	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	lence of):	e .			
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OX OR	certific Iding p	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnar	ncv				
<u>n</u>	death e atten d for u	Iclan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2□Fetal 4□Pregnant at time of de	death 3 Ectop	ic pregnancy (specify)		23d. Date of delive Month	ny Day Year
л Э	at the	Phys	9 Unknown	9□ Unknown					
ds,	signed d be d	ě	Part II. Other significant conditions co	intributing to death but not resu	fting in the underlyi	ng cause given in Part I.	23e. Did tobacco	use contribute to th	>
cords	s been shoul	lete					24a. Was an		osy findings available
ב ב	The fa	Completed					autopsy performed? 1 ☐ Yes 2 X N	prior to cor death?	npletion of cause of
<u> </u>	ician: Sertifici ector,	Be	25. Was case referred to medical examiner?	Hospital:			eath (Check only one)		
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2	or Atter de Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, fa	ctory, office	28f. Location (Street a City or Town, Stat	nd Number or Rura e)	Route Number,
_1	spital lours e neral [29a. Certifier 1 Certifying Phy	ysician: To the best of my know	vledge, death occur	red at the time, date and ola	ce and due to the cause(c) and manner as at	atod
	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 brous effer death. within 24 brous effer death. completely filled in by the funeral director, page 2 should be detached for use as the tompletely filled in by the funeral director, page 2 should be detached for use as the tompletely filled in by the funeral director.	edical	(Check only 2 Medical Exam one)	iner: On the basis of examinati and manner stated.	on and/or investiga	tion, in my opinion, death oc	curred at the time, date an	d place, and due to	the cause(s)
	To To the	Σ	29b. Signature and title of certifier	115		29c. License number	- and	ate signed (Month, I	Day, Year)
			30. Name and address of person who c	g MD	23a) (Timo Briet)	D 00 633		12910	+
			1 . 4	AWH PER	6 0 7	DUTCHM	AN'A LAT	VE. FAC	TON-21601
	Sta Registra		31. Date filed (Month, Day, Year) AUG 3 0	32. Regertrar's Signate	ure A	elle o		, , , ,	
			*****		100	The state of the s			1

			1- State of Maryland / Deparement	rtment of Health and N tificate of Death		giene Reg. No. 2007	29440	
4	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	23, 2007 ear	3. Time of Death 7:00 A.M	
	/Medic Examin		Arlene M. Card 4a. Facility Name (If not institution, give street and number) St. Mary's Hospital	4b. City, Town, or Location of Death Leonardtown	August	4c. County of Dea St. Mary	th	
ا	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthday</i>) 1 M 2 ▼ 73 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day 12/21/	year) 1933 Mai	thplace (State or Foreign ountry) Cyland	
	Maryland -f show fied at	tor	Usual Residence of Decedent 10a. State				10d. Inside City Limits 1 □ Yes 2 X I No	
	with the	I Director	10e. Street and Number 22702 Athlone Drive	10f. Zip Code 20634		10g. Citizen of What Co United Sta		
220	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	∐ Jas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto □ Yes 2t√x No <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
N-C1717	i within 72 hou jiene. r than "naturi the Merica E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 16a. Decede (Give k life. D. College (1-4or 5+) House	ent's Usual Occupation ind of work done during most of work O NOT use retired) wife		16b. Kind of Business Homemaker	/Industry	
ana	ild be filed lental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last) James William Dixon	18. Mother's Name Margaret		Maiden Surname) Whaley		
Mary	nd 2 shou alth and M 27 is mar r traumat	-	19a. Informant's Name/Relationship (Type. Print) Vickie L. Hoyle (Daughter) 19b. Mailing 26846	Address (Street and Number or Rur Morganza Turner	Rd., Me	er, City or Town, State, echanicsvil	Zip Code) 1e, MD 20659	
alumore,	Pages 1 a ent of Hec nt: If item ry or othe			ition (Name of atory or other place) e Highlands 8/28,	Date /2007	20c. Location - City or Port REpub	Town, State	
Dall	permit. I Departm Importar any Injur		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility 105 Broomes Island Ro	Rausch	Funeral Ho Republic, Mar		
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		or respiratory ar	rest,	Approximate Interval Between Onset and Death	
	/Medical Examiner		Due to (or as a consequence of):				hours	
	ecuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c		.,,		hours	
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cords, r.	equires that en signed by ould be deta	b	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.		obacco use contribute t		
אוומו חפכנ	To the Hospital or Attending Physician: The law ro Within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sho	Completed			1□ Yes	sy prior to rmed? death? 2 No 1 □ Yes	utopsy findings available completion of cause of	
	nyslcia iis certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → No	26. Place of Deat 3 DOA Other: 4 Nursing Ho		ne) lence 6 □Other (Spe	ecify)	
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Š	ital or Att rs after de ral Directo led in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (S City or Tow	itreet and Number or R rn, State)	ural Route Number,	
	the Hosp nin 24 hou the Fune npletely fil	Medical	29a. Certifier (Check only one) CertifyIng Physician: To the best of my knowledge, death and manner stated. Check only one) Medical Examiner: On the basis of examination and/or investigation.	estigation, in my opinion, death occur	rred at the time,	date and place, and du	e to the cause(s)	
	To with	2	29b. Signature and title of certifier	29c. License number 4 G3519		A CALL 7		
)	20		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint) Puist looku-1 Ro	(eoner)	August 23	20650	
1	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, P 31. Date filed (Month, Day, Year) Atig 2 7 2007	Sparke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Wayne	Cheatham	Cash, Jr.	
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	1- For State Registrar	Certificate of	Death	Reg. No.					
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Wayne Cheatham			2. Date of Death Month Day August 25, 2007	Year 0433 hrs County of Death				
	4a. Facility Name (if not institution, give street and n Prince Georges Hospital Center		4b. City, Town, or Location of Death Cheverly	Prince George's					
Funeral Director	5. Social Security Number 6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 28 yrs	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	_	D/YYYY) 9. Birthplace (State or Foreign V A				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced If Yes, Give Ye or Dates: 15. Decedent's Education (Specify only highest gr. Elementary/Secondary (0-12) College 1 2 17. Father's Name (First, Middle, Last)	Road accedent Ever in U.S. 13. Was lf Y 2 X No 1 ade completed) 16a. Deceder during m Serv Cash, Sr.	nkirk 10f. Zip Code 20754 as Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto Yes 2 X No specify: at's Usual Occupation (Give kind of votes of working life. DO NOT use retire ice Merchandis 18.Mother's Name Patric	vork done red) . Verse (First, Middle, Maiden Sce C C C	14. Race - American Indian, Black, White, etc. Specify: Black and of Business/Industry anding Surname) Ooper				
	19a. Informant's Name/Relationship (Type, Print) Patrice Cash—Sprigg 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal 4 Donation 5 Other Specify: 21. Signature of Funeral Service Micensee	ichmond, VA eral Home nce Fred.,MD							
Physician Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
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ecuted and transit	events resulting in death) Last Due to (or as d.	a consequence of):							
box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit	EZ3h was decedent prednant in the	s, outcome of pregnancy	etal death 3 Ectopic pregnather (Specify)		d. Date of delivery Month Day Year				
P.O. E s that the c gned by the c detached by the by the c detached by the by the c detached by the Phy		to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown				
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as localized Certification: To Be Completed by Physician				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
cian: 1	25. Was case referred to medical		26.Place of Death (Check						
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ion of itending I leath. tor: Afte funer		oth, Dav Year) 5, 2007 0304 hrs	1 Yes 2 ✔ No	Driver motorcycle	e fixed object collision				
Division o spital or Attending hours after death. neral Director: After filled in by the fune.	3 Suicide 6 Could not be determined (Specific	ace of Injury - At home, farm, stre (y) Major Road / Highwa			and Number or Rural Route Number, City old Central Avenue, , MD				
To the Hospita within 24 hours To the Funeral completely fille		is of examination and/or investiga	urred at the time, date and place, an ation, in my opinion, death occurred	d due to the cause(s) an at the time, date and pla	d manner as stated. ace, and due to the cause(s)				
To To S	29b. Signature and little of certifier 29c. License number 29d. Date signed (Month O.C.M.E. August 26, 2007								
2W 3	30. Name and address of person who completed of Susan Hogan MD. Assistant Med		nn Street, Baltimore, MD 2	1201					
Stat	te 31. Date filed (Month, Pan Year) 9 2007 32. Refistrar's Signature								
Registra		THE PROPERTY AND ADDRESS OF THE PARTY AND ADDR	AND AND AND AND AND AND AND AND AND AND						

			1- State of Maryland / Department of Health and Certificate of Death	Mental Hygie	_	29443						
1	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death						
ı	/Medic Examir		Janet Kathryn Carpenter 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deal	August 2	8, 2007 4c. County of Death	12:20 p ^M						
	LXamii		Carroll Hospice Dove House Westminster		Carr							
	Funeral Director		5. Social Security Number 208–16–5906 6. Sex 1 Months Days Hours Min	. (Month, Day, Ye	9. Birth Coo Penn	nplace (State or Foreign intry) isylvania						
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
	e Man 3e-f sh liffed	ctor	Maryland Carroll Westmins	ster		1 Yes 2 □ No						
	th with th	ai Director	10e. Street and Number 54 Westmoreland Street 10f. Zip Code 21157	10g.	Citizen of What Cou USA	untry?						
15-0036	d within 72 hours after death with the Maryland piene. I then "neturel", or iteme 23a or 28e-f show Ite Mudical Examiner must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puer If Yes, Give Year or Dates:	Specify Yes or No- no Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.						
לַ	"netu	ietec	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo	orking 16t	o. Kind of Business/I	ndustry						
717	within 72 iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		Own Hom	le						
Maryland 2	othe othe	Bec		me (First, Middle, Mai	,							
<u>\</u>		2	The state of the s	erine E. Mu								
	s 1 and 2 should of Health and Mer item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Printaughter Katherine E. Carpenter Smyth, 19b. Mailing Address (Street and Number or R. 54 Westmoreland Street	et, Westmin	ster, MD	21157						
gaitimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cametery, crematory or other place) Memorial Shrine Park 9/4		arverton,							
Dail	permit. Page Department of Importent: If any injury or once.	1	21. Signature of Funeral Service Licensee M01191 22. Name and Address of Facility M 91 Willis Street	yers-Durbo , Westminst	raw Funera ter, MD 21	al Home 1157						
	Physician		23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	c or respiratory arrest,		Approximate Interval Between Onset and Death						
	/Medical Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):										
	ecuted and transit	Examiner	if any, leading to immediate Due to (or as a consequence of):			ч						
ρα/ρ υ ,	ificate be executed g physician and as the burial-transit	edicai E	cause. Enter Underlying Cause (Disease on Injury that initiated avants resulting in death) Last c. Acute Renal Failure Due to (or as a consequence of): d. Acute haven Failure			h						
O. Box 6	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of deliv Month	rery Day Year						
λ. Γ	ss that gned b	by PI	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?						
	equire			1 ☐ Yes	2 No 3 Pro	bably 4 ∐Unknown						
ב ב	The law requires that the decate has been signed by the page 2 should be detached	Completed		24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of						
V 11.0	Physiclan: Th r this certificate ral director, pag	o Be	Hospital:	ath Check onl one)		T !						
5	ding Phy J. After this funeral d	H	27. Manner of Death 1 Sea. Date of Injury 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?	dome 5 Residence 28d. Describe how in		#OSPICE						
	sant eath or: the	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St		al Route Number,						
	for Att	ert	29a. Certifier 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	e Hospitel or Att	dical Certification:	29a. Certifier (Check only one) Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place 2 Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: Among the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: Among the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: Among the basis of examination and or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: Among the basis of examination and or investigation an	e, and due to the cause arred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)						
	To the Hospitel or Attanding Physiclen: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical Certi	(Check only 2 Medical Examiner:) Op the basis of examination and/or investigation, in my opinion, death occurrence.	urred at the time, date	e(s) and manner as s and place, and due t Date signed (Month,	o the cause(s)						
	To the Hospitel or Att within 24 hours after d To the Funeral Direct completely filled in by 1	edicai	(Check only one) Medical Examiner: Op the basis of examinating and/or investigation, in my opinion, death occurrence one) Medical Examiner: Op the basis of examinating and/or investigation, in my opinion, death occurrence one)	urred at the time, date	and place, and due t	o the cause(s)						
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by 1	edicai	29b. Signature and title of certifier 29c. License number 29d. Name and address of person who are eted cause if deat (Item 23a) (Type, Print)	urred at the time, date	and place, and due t	o the cause(s)						
	To the Hospitel or Att within 24 hours after d within 24 hours after d To the Funerel Direct completely filled in by 1	Medical	29b. Signature and title of certifier 29c. License number 297	urred at the time, date	and place, and due t	o the cause(s)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** ICHEL 18:35PM D 06 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ADVENTUT KOCKVILLE, MARYLAND GROVE MONTGOMERY HOSPITAL If Under 1 Year | If Under 24 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours Days Director NONE 06 2007 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No MONTGOMERY WHEATON Completed by Funeral Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number BYRON 20902 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: Specify: CHINESE 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BYRON STREET, WHEATON, MD 20902 ATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State STERI CYCLE 10/08/2007 21. Signature of Funeral Service Licensee SGAH, 9901 MEDICAL CENTER DR. ROCKVILLE, MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PREMATURITI **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any country to minimum cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director:

filled in by the fu 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and time of certifier 29d. Date signed (Month, Day, Year)

State Registrar

9901 MEDICAL CENTER DRIVE, ROCKVILLE, MO 20850 JOHNSON FAN, MD, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Peristrar's Signature

12-26620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dell Dickerson State of Maryland / Department of Health and Mental Hygiene 2007 29446 Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner 2150 hrs Dell Douglas Dickerson September 5, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Penninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) If Under 24Hrs 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Funeral Director Months Davs Hours Min 03/16/1952 Country Virginia 235-80-3180 1X M 2 55 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits fshow 1 X Yes 2 No Maryland Somerset Princess Anne Director or 28a-f 10e. Street and Number 10g. Citizen of What Country? 12073 Crisfield Lane Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2 X Married 2 X No Yes White If Yes, Give Year Widowed Divorced Yes 2 X No specify: Specify. other than "natural", ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) t. Pages 1 and 2 should be filed within timent of Health and Mental Hygiene. rrant: If item 27 is marked other that or other traumatic event, the Medic Carpenter Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barbara Alice Graham John Edward Dickerson, ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Sharon M. Dickerson/Wife Box 823, Princess Anne, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation Removal from State Department of Important: I injury or oth 9/7/2007 Crematory of Delmarva 5 Other Spe Delmar, Delaware 22. Name and Address of Facility 21. Signature of Funeral Service/Licens Zeller Funeral Home, P. 0 1212 Old Ocean City Road, 0. Box 3171 1, Salisbury MD 21802 Part I. Enter the disease, of Physician hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause Between Onset and /Medical Death Methadone and alprazolam intoxication -xaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED #<u>23a</u>, <u>27</u>, <u>28a-f</u>, perME, <u>g</u>871, <u>9</u>/25/07 TT Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown signed by the a Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ σ. 1 Yes 2 No 3 Probably 4 V Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has s certificate has rector, page 2 sl performed? death? ✓ Yes 2 1 🗸 Yes 2 No Hospital or Attending Physician: After this certifi funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital æ examiner? Hospital: 1 Inpatient Other₄ 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ۵ 1 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural Yes 2 XNo Pending Fnd 9/5/2007 9:10 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide סיד or Town, State) 21073 Crisfield Lane, Princess Anne. (Specify) found at residence determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** (Check only 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 6, 2007 a 30. Name and address of person who com seed cause of death (Item 23a) Assistant Medical Examiner Tasha Greenberg MD. 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (M

OCME

gistrar's Signatur

DH-3

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

VASANT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(ZUI MO

3 homill 57 DATTHO 32. Registrar's Signature

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MACERSTONN MD ZITHE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death James Arthur Deitzel, Jr.

2007 29448

		Registrar Certificate	o Death		Reg. No.	3. Time of Death				
Physicia ledical Examin	n/ ner	James A. Deitzel Jr. Month Day Year August 26, 2007								
		4a. Facility Name (if not institution, give street and number) 1743 W Nursery Road	4b. City, Town, or Location of Linthicum		4c. County of Death Anne Arundel					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 212–36–3817 68	y) If Under 1 Year If Under 1 Yran Months Days Hours		/1939 Co					
, any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits				
Maryland 28a-f show d at once.	후	Maryland Anne Arundel Glen Bu			40 - Oilinn - (1M/Lat On)	1 Yes 2 X No				
ne Mary or 28a	Director	10e. Street and Number 108 Governor's Court, Apt. L	10f. Zip Code 21060	100	10g. Citizen of What Cou United Stat	•				
death with the Maryland or items 23a or 28a-f sho must be notified at once	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican			ican Indian, Black,				
fter deat I", or ite	<u>u </u>	Never Married 2 Married 1 X Yes 2 No 3 Widowed 4 X Divorced or Pales:	Yes 2X No specify:			White				
hours al	eted by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	edent's Usual Occupation (Give		16b. Kind of Business/	Industry				
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	omplet	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mai	l Carrier	i iā		overnment				
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she umatic event, the Medical Examiner must be notified at once	o Be Co	17. Father's Name (First, Middle, Last) James A. Deitzel Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. M		r's Name (First, Middle, dred Wingat	te	7in Onda)				
y, MD 2121 and 2 should be fi eath and Mental I tem 27 is marked Fraumatic event,	-		03 Upper Beckle							
구 글 글 글 글	Ecul79	1 Burial 2 Cremation 3 Removal from State crematory	sposition (Name of cemetery, or other place)	Date	20c. Location - City or					
Baltimore, sernit. Pages 1 ar Department of Hee Important: If ite Injury or other w		4 Donation 5 Other Specify: Carroll	Cremation 22. Name and Address of Facilit	8/29/2007						
Balti permit. Departir Importa		M01490	Main Street Har	mostead Ma	neral Home 9 ervland 2107					
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not el failure. List only one cause on each line.	nter the mode of dying, such as o	cardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and Death				
kaminer		Immediate Cause (Final disease or condition resulting in death) Intraoral gunshot wound Due to (or as a consequence of):				Beaut				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause								
ed isit	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
execut an and al - tra		d. UNPENDED AMENDED								
8760, tificate be ex ng physician as the burial	n/Medical	IF FEMALE: 23b. Was decedent pregnant in the propert 42 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopi	ic pregnancy	23d. Date of deliver	ry Day Year				
	Physicia	past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)							
ords, P.O. Box 6 w requires that the death cer s been signed by the attendi		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in P		tobacco use contribute to					
IS, P.	ted by			1 Y	es 2 ✔ No 3 Pro	utopsy findings available				
e law rece la has berege 2 shou	Completed			auto peri	opsy prior to formed? prior to	completion of cause of				
Vital Reconsiders: The this certificate	o l	25. Was case referred to medical		(Check only one)	2010	65 2 110				
1 of Vital Rec ling Physician: The I After this certificate I	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp. 27. Manner of Death	e of Injury 28c. Injury at Wor	Nursing Home 5	Residence 6 Other	er: Scene				
ion of tending Pt eath. tor: After the funeral	ation:	1 Natural 5 Pending FOUND: Accident Investigation Page 1500 h): 1 Yes 2	 Subject sh 						
Division of Vital Records, ital or Attending Physician: The law require urs after death. ral Director: After this certificate has been sittled in by the funeral director, page 2 should be a second or the funeral director, page 2 should be a second or the funeral director.	Certification:	3 ✓ Suicide 6 Could not be determined (Specify) Hotel/Motel	, street, factory, office building, e	or Town	(Street and Number or R State) sery Road, Linthicum,					
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or inversand manner stated.	occurred at the time, date and pi stigation, in my opinion, death o	lace, and due to the ca ccurred at the time, dat	use(s) and manner as sta te and place, and due to t	ited. he cause(s)				
in IL	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mi					
BHIVA		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111	Penn Street, Baltimore,	MD 21201						
Sta	ate	31. Date filed (Month, Day, Year) 32. Figistrar's Signature								
Regist DHMH 17 Rev 1/20		AUG 2 9 2007 Klesus K.	Jacobs .		OCME					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Day Month **Physician** Frances Deitz 24, 2007 11:30A August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2012 Cascade Road Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 M 2 K F Director 219-05-6652 87 December 24,1919 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 K No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2012 Cascade Road 20902 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 X Widowed 4 ☐ Divorced Year or Dates: 'natural', White Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Engle 2 Harry Kitt or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If Item 27 is any injury or other trau Lori Meyer - Granddaughter 10 Cedarlawn Road, Irvington, New York 10533 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State Judean Memorial Gardens 8/27/2007 4 Donation 5 Dother (Specify) Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the discase, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): **Examiner** Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☒ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Dysphagia Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2∏ No 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \ Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 2 No 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D00034726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Jasmine m. 0 Jaft1 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 29 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29452 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** RTCHARD FRANCIS DOWNING 24, 2007 August 10:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8600 Jones Mill Road Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
July 24,1929 9. Birthplace (State or Foreign Country)
PA 7. Age (In yrs. last birthday, **Funeral** 1XM 2□ F 78 177-22-8065 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~- " any injury or other traumatic exercises." 10a, State 10c. City, Town or Location 10d, Inside City Limits 10b. County MD Rockville Montgomery 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? United States 14211 Woodcrest Drive 20853 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1952 − If Yes, Give Year or Dates: 1954 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2X No White <u>۾</u> Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Architect Architecture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Kinney Herbert Downing 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis L. Downing (Wife) 14211 Woodcrest Drive Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 20c. Location - City or Town, State 28 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. Silver Spring, MD 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home Curtis 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Siezure Disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Coronary Artery Disease attending physician and for use as the burial-trar Due to (or as a consequence of) চিক Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2【X No 24a. Was an 1□ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartificator prompletely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Assisted 5 Residence 6 K Other (Specify) Living 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H51280 August 27, 2007

State Registrar

9715 Medical Center Dr. #201 Rockville, Md. 20850 31. Date filed (Month, Day, Year) ₩gistrar's Signature AUG 29 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Anushiravan Dadgar M.D.

			For State Registrar	State of Ma	ryland / E	Depar <i>Certi</i>	tment of H	lealth ai Death	nd Me		ien 20	07	29453
	Dhualai		1. Decedent's Name (First, Middle, La	st)					2.	Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		Joseph	Frederick	Dual,	Sr.				August	24,	2007	12:45 A ^M
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)		4	4b. City, Town, or	Location of	Death		4c. Cour	nty of Oeath	
			Manor Care of Pot				Potoma		411			ntgome	
	Funeral		5. Social Security Number 6. S	Sex 7.Age SaXIM 2□F	(In yrs. last birt		If Under 1 Year Months Days	If Under 2	Min.	Date of Birth (Month, Day	, Year)	Cour	
2	Director		320-09-9048 Usual Residence of Decedent		90	113.			J	an. 24	, 191	/ Lou	isiana
	iand ow		10a. State 10b. County		10c. City, Town	or Loca	ition				-	1	0d. Inside City Limits
	Mary -1 eh	jo	Maryland Montgom	erv	Poto	mac							1 ☐ Yes 2X No
	r 28a	Directo	10e. Street and Number				10f. Zip Code			1	0g. Citizen	of What Cour	ntry?
	3a o		9304 Falls Bridge	Lane			2085	54			Uni	ted St	ates
	deat	Funeral	11. Marital Status	12. Was Decedent E		13. Wa	as Decedent of Hi		in? (Specif	y Yes or No-		lace - Americ	
9	or Ite		1 Never Married 2 Married	1 2 Yes 2 □ N	。1943-		Yes 2⊠No		Fuelto Hic	an, etc.)		lack, White,	etc.
8	be filed within 72 hours after death with the Maryland ital Hyglene. do other then "neturel", or lieme 23a or 28e-1 ehow event, the Medical Eracrical must be notified at	d by	3X Widowed 4 □ Divorced	Year or Dates:	1944		1103 223110	Specify.			Spe	Cre	eole
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72	e filed vell Hygie other i		17. Father's Name (First, Middle, Last	3		Exec	cutive 0			First, Middle,			ernment
and	ntal l	Be c		A. Duell				10. 141011101					
2	d Me	٩	19a. Informant's Name/Relationship (19h	Mailing	Address (Street a	and Number		Essie Route Number	Rei		(Code)
Ma	id 2 s ith ar 27 is 1rau		Dorothy M. Dual,				Falls Br						•
Baltimore, Maryland 21215-0036	es 1 and 2 should be for the solution of Health and Mental For them 27 is marked of rother traumatic ever		20a. Method of Disposition	, r, baagnee	20b. Place of	Disposit	ion (Name of		Date			n - City or To	
υO	ages ant of it: If I		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif				tory or other place 1s Cemet	1	Q/31/	2007	Potom	ac Ma	rv1 and
Ħ	permit. Pages: Department of timportant: If Ite ony Injury or ot		21. Signature of Funeral Service Lice		00		Name and Addres						Lyland
B	Deg E g		N . 0. (JA Xe	XX.	10000000							D. 20877
	700		23a. Part1. Enter the disease, or com	plications that caused	the death. Do n			-	-				Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final										Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a. Urosepsi Due to (or as a	onsequ <i>e</i> nce o	of):							
	Examiner			_{b.} Aspirati			a						
	7 7	lner	Sequentially list conditions, if any, loading to inimical accesses. Enter Underlying Cause (Disease or injury	Due to (or se a	s domenquence o	offe							
	ocuted nd transi	Examin	that initiated events	_{c.} Dysphagi									
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8760,	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical		_{d.} Esophage	al Refl	ux D	isease						
9	eath certific attending p for use as 1	/Me	IF FEMALE:	220 Hyan outcome	of programmy			-				11:0 ==0:0	
Вох	attend attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal death		ctopic pregnancy				1	Date of delive Month	ory Day Year
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	ime or death	5 L C	Other (specify)						
<u>α</u>	that the de led by the a detached t		Part II. Other significant conditions of	contributing to death bu	t not resulting in	the unde	erlying cause give	en in Part I.		23e. Did to	bacco use co	ontribute to th	ne cause of death?
Vital Records,	89 69	d by	Hypertension				, ,			1 🗆 Y	es 2□No	3 Prob	ably 4 XUnknown
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Re	has has	du	Diabetes Meiliti	.5					_	autops	sy		nptetion of cause of
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on	tending leath. tor: After the funer	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	Year) Ir	njury		k? Yes 2∐N	lo				
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	To the Hos within 24 h To the Fur completely	Medica	one)	and manner sta	ted.								` '
	i		29b. Signature and title of certifier	. 1/AP	1 - h	11	29c. License					ned (Month,	
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,			30. Name and a dress of person who					a Mas	ev1 an	a 2001	7		
W.	Sta	te	Kirti Vohra, M.D. 31. Date filed (Month, Day, Year)	32. Sgistra	r's Signature	/u • ,	Dernesa	a, Mal	гутан	u 2001	/		
47,4	Registr		AUG 292	32. Agistra	w K.	Sport	Will						

			1 - For State Registrar	State	of Mary	land / Depa	artment of Hertificate of E	ealth and Death	Mental Hy	giene (07	29454	
	Physici /Medic		1. Decedent's Name (First, Middle Harriet	R. Dougl	as				2. Date of De Month August	Day	2007	3. Time of Death 11:28 🏚	
	Examin		4a. Facility Name (If not institution Suburban Hos	17.00	ımber)		4b. City, Town, or Bethe		th	4c. County of Death Montgomery			
- *	Funeral Director		5. Social Security Number 228-18-5795	6. Sex 1 ☐ M 2 ☐ F	7. Age (In	yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birt (Month, Da 12/25/1	f Birth 9. B		place (State or Foreign htry) JA	
	ehow	'n	Usual Residence of Decedent 10a. State 10b. County		100	c. City, Town or Lo					1	0d. Inside City Limits 1 X Yes 2 □ No	
	n the M or 28a-f	Director	D.C. 10e. Street and Number			wasnii	ngton, D.C) •		10g. Citizen	of What Cour		
	23a c		·	. SW Apt.				20024-2			JSA	and the disc	
036	ours after de el', or Item Exeminer	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 ☑ Divorced	If Yes, G	orces? 2 🔀 No ive		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☒ No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - Americ Black, White, ecify: Wh		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or Items 23a or 28a-f show say injury or other traumatic event, the Modical Examinational be muitted at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done during mos life. DO NOT use retired) Traffic Manager 17. Father's Name (First, Middle, Last)						08			_{dustry} nent Office	
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Maryland	should nd Men marke umatic	ဥ	John William Revnolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									Code)	
	l and 2 fealth a im 27 is		Donald R. Baia	rdo/Nephe		1061(Manor Ct	. Manas	sas, VA		0'h T		
Baltimore,	Pages 1 nent of H int: if its iry or ot		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	cemetery, crei	natory or other place J. Meth Ch C	· 1	9/1/07		on - City or To allao,		
Balti	permit. Departmit. Imports eny inju		21. Signature of Funeral Service	Licensee		22	Name and Address	s of Facility	11.00			22203	
- to		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Applications that cause of each line. Immediate Cause (Final disease or condition resulting in death) a. LAPPUT CAT bleed control to the late of the											
A.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. IA D C	(or as a co	nsequence of):	edicitu	kisto	ry of	ulc	27		
200	Examiner	er	Sequential y list conditions,	b		nsequence of):							
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	w requires that been signed b should be deta	þ	Part II. Other significant conditions of the Styoke	ons contributing to	death but no	ot resulting in the u	nderlying cause give	n in Part I.	1	obacco use o		he cause of death?	
Vital Records,	The law requisate hes been page 2 should	Completed							24a. Was autop perfo 1 Yes	an 2- osy rmed? 2 No	4b. Were auto prior to co death? 1 \(\sum \text{Yes} \)	psy findings available mptetion of cause of	
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J Of	tending Physician: The seath. tor: After this certificate he tor: After this certificate he the funeral director, page	-	1 Yes 2 No 27. Manner of Death	28a. Date		2XER/Outpatier 28b. Time o Injury	IL 3L DOA	4 Nursing I	Home 5 Resident			v)	
Division of		Certification:	1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation not be 299 Plac		At home, farm, str	M 1 □ Y	es 2 No	28f Location (Street and N	Imber or Purs	al Route Number.	
<u>≥</u>	ital or A rs after el Dire ed in by		4 Homicide determ		ling, etc. (S		eet, factory, office		City or Tov		311001 01 71012	ir node Number,	
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1	To the H within 24 To the Fi complete	M	29b. Signature and title of certifie	ِرِ ا			29c. License			1	gned (Month,	,	
)	(1)		30. Name and address of person	who completed cau	se of death	(Item 23a) (Type,	Print)	54566		0 2	-9107	-	
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ohn Arthur Edel			ite of Maryland / I				d Ment	al Hygiene	2.0	07	201.5
	F	- For State Registrar		Cen	tificate of E	eath_			g. No. 20		2945
Physicia	n/	Decedent's Name (First, Middle	,Last)					Date of Death Month	n Day Year		of Death
Medical Examir	ner	John	Arthur		Ede	len		Month August 25,	2007	002	25 hrs
		4a. Facility Name (if not institution	, give street and number)			City, Town, or	Location of	Death	4c. County of De		
		4142 Bunker Hill Road			(Cottage City	y		Prince Geo	rge's	
Funeral	7	5. Social Security Number	6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Yea	r If Under	24Hrs. 8. Date of Birtl	n(MM/DD/YYYY) 9.	Birthplace (State or
Director						Months Day	s Hours	Min. 12/25	5/1942 Fo	reign Maj	ryland
Birootor	L	213-42-6205	1 X M 2 F	54	Yrs.			12/23	0/1942	Country)	
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and sho	5 P	Maryland Princ	ce Georges		Cotta	ıge Ci	ty			' X	Yes 2 No
hours after death with the Maryland natural", or items 23a or 28a-f show Examiner must be notified at once.	Director	10e. Street and Number			1	0f. Zip Code		10	g. Citizen of What C	Country?	.11
he M	盲	4142 Bunker H	ill Poad A	nt	210	2072	2		USA		
s 23s		11. Marital Status	12: Was Decedent E					in? (Specify Yes or No-		merican Indi	an, Black,
ath v	Funeral	1 X Never Married 2 Ma	rried Armed Forces?	_	If Yes	specify Cubar	, Mexican,	Puerto Rican, etc.)	White, et	٥.	
er de		3 Widowed 4 Divo	rced if Yes, Give Year	No	1 🗆 🗸	es 2 X No	specify:		Specify: B	lack	
5-0036 ed within 72 hours after tygiene. other than "natural", the Medical Examiner	<u>.</u>	15. Decedent's Education (Spec	or Dates:	otod\				ind of work done	16b: Kind of Busine		61.0
hour	Completed					of working life			· ·· · · · · · · · · · · · · · · · · ·	33/11/4/3/19	
	i et	Elementary/Secondary (0-12)	College (1-4 or 5+)					3		
5-0036 led within 72 lygiene. other than "	Ē	12			Self-E	mploy			Agricu	ture	:
5-C		17. Father's Name (First, Middle,	_ast)				18.Mother's	s Name (First, Middle, M	laiden Surname)		:
MD 21215-0036 and 2 should be filed within 72 ath and Meintal Hygiene.		Bernard F		E	delen		Anni	e E		3owma	
221 hould hould is ma	2	19a. Informant's Name/Relationsh	ip (Type, Print)					ber or Rural Route Num			
2 sho h and h and mati	- 1	Mary A.Brown	/ Sister		5506 N	Tewton	St.	Apt.3 Hya	ttsville	∍,Mar	yland
imore, MD Pages 1 and 2 sho ment of Health and fant: If item 27 is or other traumati		20a. Method of Disposition			Place of Disposition		metery,	Date	20c. Location - Cit	y or Town, S	State
Ore toff		1 X Burial 2 Cremation		7	rematory or other	. ,	- 1	0/5/2007	Clinton	Moss	
Baltimore, permit, Pages I an Department of Hea Important; If iter injury or other tra		4 Donation 5 Other Sp.		Ke	surrec			9/5/2007	CITHCON	, Mar	yrand
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2.2 Q A		1 Juyel 11	Mess	1	91 206	05 Ag	uasc	o Rd. Aqua	sco, Mary	zland	20608
Physician	- [23a. Part I. Enter the disease, or of failure. List only one cause of		e death.	Do not enter the	mode of dying,	, such as ca	ardiac or respiratory arre	est, shock, or heart		oximate Interval veen Onset and
/Medical		Immediate Cause (Final disease	a Complications of	Chron	ic Alcoholism					1	Death
xaminer	П	or condition resulting in death)	Due to (or as a conseq					13415			
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ig. g	ă	events resulting in death) Last	Due to (or as a conseq	uence of	·):						
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ox 68760, eath certificate be e attending physicia for use as the buria	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregi	nancy				23d. Date of del	ivery	
387 rtiffic ing p	a a	23b. Was decedent pregnant in the past 12 months?	Live Ditti		-	death 3	Ectopic	pregnancy	Month	Day	Year
th ce	<u>:</u>		4 Pregnant at til	me of de	ath 5 Othe	r (Specify)			Sec.		- 1
Box death c the atten	اچ	1 Yes 2 No 9 Unk	9 Unknown				-	<u> </u>			
that the dined by the detached	<u>a</u>	Part II. Other significant conditi	ons contributing to death	but not re	esulting in the und	derlying cause	given in Pa		bacco use contribut		
, P.O.	t by	Hypertensive Atheros	clerotic Cardiovascul	ar Dise	ease			1 Yes	2 V No 3	Probably 4	4 Unknown
Division of Vital Records, tal or Attending Physician: The law requing a flee death all Director: After this certificate has been siled in by the funeral director, page 2 should the	Completed							24a. Was a			ndings available
aw ranas b	희							autop	sy prio med? deal		ion of cause of
Vital Rec ysician: The l his certificate l	6							1 🗸 Yes		Yes	2 No
tal Rection: The certificate ector, page	Bec	25. Was case referred to medical				26.Plac		(Check only one)			
/its	0 B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2	ER/Outpatient	3 DOA	Other ₄	Nursing Home 5	Residence 6 🗸 0	Other: Scene	•
fing Phy After th	-1	27. Manner of Death	28a. Date of Injury	<i>/</i> .	28b. Time of Inju	ıry 28c. İnji	ıry at Work	? 28d. Describe	now injury occurred		
e fur h	힐	1 V Natural 5 Pend	(Month, Day, Yea	ar)		1	Yes 2	No			
Sior	g		tigation 28e. Place of Inju	n/ - At h/	ome form street	factory office	huilding et	c 28f Location (S	Street and Number of	or Rural Rou	ite Number City
Divi	뛜		not be	ny - At In	one, rann, succe,	lactory, office	bulluling, co	or Town, S		Train Troo	no rumbor, ony
2 2 2 2	Certification:	4 Homicide	(5/2007)								
e Ho 124 } e Fu		29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowled	ge, death occurre	d at the time, d	late and pla	ace, and due to the caus	e(s) and manner as	stated.	-(a)
To the Hosp within 24 ho To the Fun completely i	Medical		niner: On the basis of exami	ination a	nd/or investigatio			curred at the time, date			
F = F 0	ž	29b. Signature and title of certifie				29c. Licen:	se number		29d. Date signed	(Month, Day	y, Year)
		1 1/	//			O.C.	M.E.		August 25, 20)07	
		30. Name and address of persons	who domnlated article of do	ath /Item	23a)						
S 12 0	ME	Mary G. Ripple MD.	Deputy Chief Medica			Penn Stree	t, Baltim	ore, MD 21201			
, 242			22 Anietroris								
St Regist	ate	31. Date filed (Month Day Year)	2007 Serve	Joignall	& Soci	le					
regis	بلئد			-							

			For State Registrar		State	e of Ma	rylan		artment rtificate			and M	ental Hy	giene Reg. NZ. (007	2945	57
***	Physicia		Decedent's Name (Fin Paul	rst, Middle, Las Edward		•							2. Date of De August	Day 30	2007	3. Time of De 11:03	
	/Medic Examin		4a. Facility Name (If not 10 S. De1			d number)			4b. City,		Location o	f Death			unty of Death		
F	uneral		5. Social Security Number	er 6. Se	×		(In yrs. I	ast birthday)	If Under	1 Year	II Under	24 Hrs. Min.	8. Date of Bir (Month, Da	h	9. Birth	place (State or F	oreign
Di Di	irector		218-04-738 Usual Residence of Dec	38 -	(] M 2 □	F	42	Yrs.	Months	Days	Hours	MIII.	June/1			erick,	MD
yland	Mon I			o. County	,		10c. City	, Town or Lo	cation					· · · · · · · · · · · · · · · · · · ·		10d. Inside City I	
e Mar	infind a	ctor	MD F	rederio	ck		B:	runswi	ck							1 XYes 2	□ No
with th	3a or 28 st be no	al Dire	10e. Street and Number 10 S. De1		Ave.				10f. Zip	Code 2171	6			10g. Citizer	of Whal Cou USA	ntry?	
21215-0036 d within 72 hours after death with the Maryland oiane.	item 27 is marked other than "neturel", or items 23a or 28a-f show other traumatic event, if a Modical Examinat must be notified at	Completed by Funeral Director	11. Marital Status 1 ☑ Never Married 3 ☐ Widowed 4 ☐		Arme 1 🗆 Y	Decedeni E ed Forces? fes 2 N s, Give or Dates:		1	Was Deced If Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.)		Race - Amer Black, White Decify: Whi	elc.	
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ω >	marked other than "neturel",	BeC	17. Father's Name (First	t, Middle, Last)	-			Cust	outan		18. Mothe	r's Name	(First, Middle		lucatio	n	
arylar should b	atic e	To E	Russell El	1sworth	Eur	y, Sr					Anna	Eli	zabeth	Lam			
20 20	ra m		19a. Informant's Name/)							l Route Numb				
e, K	em 27 ther t		Anna E. Eu		other		20b. P		. Dela				runswi) 2171 tion - City or T		
Baltimore, permit. Pages 1 a Department of Hea	Important: if item 2 eny injury or other i		1 ☐ Burial 2 ☐ Cr	emation 3 🗆	Removal f	rom State		lace of Dispo				10.10	_				
Iltin	ortan Injur		4 □ Donation 5 ☑	I Service Licen		mbment	Mer)/2/0	7 neral I		rick,	MD	
B F G	e e g		Barbara	A. W11	liam.	Llowi	iei	- T					d, Bru		. MD	21716	
760, te be executed XI	physician and edical aminer transit	icai Examiner	shock, or heart fail Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to minude cause. Enter Underflyin Cause (Disease or injun that initiated events resulting in death) Last	ons.	a. M# Du b. Du	e to (or as a	consequence of the consequence o	uence ol):	enoca	PC11	NOME	t of	THE	Color	V	Interval Betwe Onset and Dea	
Box 6	led by tha attending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent preint the past 12 mon 1 Yes 2 No 9 Unknown	ths?	es, oulcome of pregnancy Live birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify)							230	23d. Date of delivery Month Day Year				
ecords, P.O	been signed b should be deta	by	Part II. Other significan	t conditions co	ontributing	to death bu	t not resu	alting in the u	nderlying ca	ause give	n in Part I.		23e. Did t			he cause of dea	
Rec he law	ste has paga 2	Completed			24a. Was an autopsy performs						osy	24b. Were aut prior to codeath?	opsy lindings ava empletion of cau	allable ise of			
/ita	cartificete rector, pag	Be	25. Was case referred to examiner?	-	Hospital					Othe		of Death	Check only	one/			
Division of Vital to Attending Physician:	fter this inaral di	ation: To	1 Yes 2 No 27. Manner of eath Natural 5	Pending investigation	28a. [1 ☐ Inpatier Date of Injun (Month, Day	v	ER/Outpatier 28b. Time o Injury		Bc. Injury Work	4 🗆 NU		ne 5 Resi 28d. Describe		Other (Spec	<i>fy</i>)	
Divis	To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 4 Homicide	Could not be determined	280. F	Place of Inju building, etc	ry - At ho . (Specify	ome, larm, st	reet, factory	, office		2	28f. Location (City or To		Number or Rui	al Route Numbe	9r.
Hospit 24 hours	Funera etely fille	edicai (29a. Certifier 15 (Check only 2 one)	Certifying Phy Medical Exam	iner: On t	o the best of the basis of manner stat	examina	wledge, deat tion and/or in	h occurred vestigation,	at the tim in my op	e, date an pinion, dea	d place, a th occurre	and due to the ad at the time,	cause(s) ar date and pl	id manner as ace, and due	stated. to the cause(s)	
To the	To the	Me	29b. Signature and title	of certifier	76	0				-	number			29d. Date :	signed (Month	Day, Year)	
			> from	PH-C	Con	nd	MA		41	1 3	176	/		8/3	11/20	07	
6			30. Name an address of	of person who	completed	cause of de	eath (Item	23a) (Type,	Print)	TH	ST.	Fre	EDEPLICE	EM	D 21	701	
	Sta Registr		31. Date filed (Month, D	G 3 1 2	007	32. legistra	r's Signa	or w.	news.					1			

			For State Registrar	State of Ma	arylan		artment of I <i>rtificate of</i>		nd Mental F		ne No. 20	07	29458
Phys	iciar		1. Decedent's Name (First, Middle, La	st)	-				2. Date of Month	Death	Day	Year	3. Time of Death
	dica	ı,	ELIZABETH SHIRLI	·					AUGUS			_	6:00 P M
Exam	nine	r	4a. Facility Name (If not institution, giv		****		4b. City, Town,				4c. County		
Funds		4	3701 CAPTAIN WEND 5. Social Security Number 6. S			last birthday)	FORT WA				PRINCE		RGES place (State or Foreign
Funer Directo			577 46 2388	□M 2 X F	72	Yrs.	Months Days			Day, Ye	- 1	Cour	carolina
and		- H	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation					1	0d. Inside City Limits
Mary I-f sho fied a	3	5	MD PRINCE G	EORGES	FOR'	T WASH	INGTON						XXYes 2 □ No
th the or 28a	Director	20	10e. Street and Number		<u> </u>	V-77	10f. Zip Code			10g.	Citizen of W	hat Cour	ntry?
ath wi 23a ust b			3701 CAPTAIN WEND	ELL PRUITT	WAY		20744			US	SA		
Ind 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	hy Funeral	2	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Tyes 2 Th If Yes, Give Year or Dates:			Was Decedent of I If Yes, specify Cub 1 ☐ Yes 🍇 No		n? (Specify Yes or Puerto Rican, etc.)	No-	Black	- Americ c, White, BLAC	
5-0036 72 hours af natural", or lical Exami	to		15. Decedent's Ed (Specify only highest gra	lucation		16a. Dece	dent's Usual Occu	pation	f working	16b	. Kind of Bu	siness/Inc	dustry
ithin ne.	Completed		Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done DO NOT use retire		i working				
d 21 Hygier ther th			12TH 17. Father's Name (First, Middle, Last)			FOOD	SERVICE I		Name (First, Midd		VERNM		
e d ala be	TO B	2	WILLIAM HAILE						STEWART	ue, mac	ien Surnami	<i>₹)</i>	
Marylar d 2 should be th and Menta 7 is marked traumatic ev			19a. Informant's Name/Relationship (Type. Print)		31 9 0 Mailir	ya Ads ira ss (Sitee)		PRULIT	nber Cit	ty or Town, S	State, Zip	Code)
		38	MELIZZA_FORD/DAUG	HTER			WASHINGTO			WAY			
of H		1	20a. Method of Disposition XXX Burial 2 □ Cremation 3 □	Removal from State	C	lace of Dispo emetery, crei	sition (Name of matory or other pla	ice)	Date	20c.	Location - 0	City or To	own, State
altimore, mit. Pages 1 ar partment of Hea portant: if Item y Injury or other			4 □ Donation 5 □ Other (Specify	y)	FORT		OLN CEME		8/23/200		ENTWO		
Baltimo permit. Page Department Important: If	ouce		21. Signature of Juneral Service Licer	Ill					ARSHALL' D SUITLA				E
51.56		1	23a. Pa . Enter the disease, or com shock, or heart failure. List only	plications that caused	the death								Approximate Interval Between
Physicia	n	1	Immediate Cause (Final disease or condition				M OF LARY						Onset and Death
/Medica Examine			resulting in death)	Due to (or as a			- VA HALL	14323					
	В.	,	Sequentially list conditions,	b. Due to for as a	conse ii	ience of						_	
uted 1	Examiner		cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for us	z conse şe	arrive one						Ì	
O, exect an and nial-tra			resulting in death) Last	Due to (or as a	consequ	uence of):						-	
68 / 60, ficate be executed physician and is the burial-transit	edical	5		.d									
	Med		IF FEMALE:	00-11									
COTAS, P.O. BOX to require that the death certiful been signed by the attending should be detached for use as	Physician/M	1	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ②\(\frac{7}{2}\)\(\fra	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 🗌 Fetal	Ideath 3	Ectopic pregnanc Other (specify)	у		-	23d. Date Mon		ery Day Year
ords, P.C requires that the een signed by th nould be detache	by P		Part II. Other significant conditions						23e. Di	d tobacc	o use contri	bute to th	e cause of death?
ecords, law requires t as been signe 2 should be o			SECONDARY MALIGNA	INT NEOPLAS	SM OF	LUNG	BONE AN	D SKIN	_ 1[□ Yes	2 ☐ No	3 ☐ Prob	ably XXUnknown
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The cate har page	S								pe 1□ Yes	rformed'	? de	eath?	•
Or VITAI ME Physician: The la r this certificate has	8	1	25. Was case referred to medical examiner?	Hospital:			Oth		Death (Check only				
Physer this eral di	2		1 ☐ Yes 2 X No 27. Magner of Death	1 ☐ Inpatier		ER/Outpatien 28b. Time of	L 3 DOX	4 LI Nursir	ng Home 5X Re 28d. Describ				/)
Attending Phrage death. ector: After the by the funeral	Certification:		1 ANatural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	Wor	rk? Yes 2∐No	230. 5030115	C 11047 111	july occurre	u	
VISI r Atten er deat rector: by the	iji		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju building, etc	ry - At hor	me, farm, str	et, factory, office		28f. Location	(Street	and Numbe	r or Rura	l Route Number,
Ital or Its afte ral Dir	Cerl			Danieling, oto	. (0,000.)	,			City of 1	OWII, 31	ate)		
To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical		29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best on niner: On the basis of and manner state	examinat	wledge, death ion and/or in	occurred at the tile vestigation, in my o	me, date and p opinion, death	place, and due to the occurred at the time	ne cause ie, date a	e(s) and mar and place, a	ner as st	ated. the cause(s)
To the within To the Comple	Me	1	29b. Signature and title of certifier			1.	29c. Licens	se number		29d. [Date signed	(Month, I	Day, Year)
			I Her.	-oh	/		D6417	8		AUC	GUST 2	1, 2	007
0-120		1	30. Name and address of person who				CAN	CER INS	STITUTE,	SUI	TE 21	51	
	tate		HARVINDER SINGH, 31. Date filed (Month, Day, Year)	32 Registra	r's Signati	ure	ET, NW W	ASHINGT	CON, DC 2	0010)		
Regis	itate strar		AUG 3 1 2007	Beren A	. 4	out							
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Margaret Rose FiTzgerald 07-06399 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 1245 hrs Medical Examiner MARGARET ROSE FITZGERALD August 18, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 26428 Arcadia Shores Road **Faston** Talbot 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Min Foreign Country) Days Months Hours Director 212-31-4511 1 M 2 X F 18 Yrs JAN 16, Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No MD TALBOT EASTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 26428 ARCADIA SHORES CIRCLE 21601 USA 23а Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Yes .. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Divorced If Yes, Give Yeer Specify: WHITE Widowed 4 Yes 2 X No specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) UNIVERSITY OF other than "n the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) STUDENT MASSACHUSETTS 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) MATTHEW EDWIN FITZGERALD t: If item 27 is marked other traumatic event, Be MARGARET WALSH ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) QW MATTHEW E. FITZGERALD/FATHER 26428 ARCADIA SHORES CIRCLE, EASTON, MD 21601 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Important: injury or oth CHESAPEAKE CREMATION CTR. 9/07/2007 STEVENSVILLE, MD Donation 5 Other Specify: 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 21. re of Funeral Service Licensee M. WSTrowski oseph 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Thermal injuries and smoke inhalation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter underrying Cause (Disease or injury that initiated PQ. Due to (or as a consequence of): events resulting in death) Last and ian/Medical X UNPENDED ^\mathbb{E}_27,28a-f,perME,g871, 9/15/07 TT Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Dav Year Pregnant at time of death Physici Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o 9 2 Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) the Hospital or Attending Physician: of Vital Be Other₄ examiner? Hospital: 1 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 Nursing Home 5 this 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural Yes 2 X No Pending Director: 2:14 am subject injured in house fire 8/18/2007 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 26428 Arcadia Shores Rd. Easton, MD within 24 hours at To the Funeral L determined (Specify) 4 Homicide other-residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. August 19, 2007 Name and address of person who completed cause of death (Hem 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month) 32. Registrar's Signature State 2007 Andrea. Registrar OCME

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

2007

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Physic /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or Iteme 23a or 28e-1 show any njury or other traumatic event, the Medical Examinar must be natified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

18 H

State Registrar 31. Date filed (Month, Day, Year)

	1 - For State Registrar	State o	i warytano		tificate of L		and ivi		Reg. No.	101	29461
	1. Decedent's Name (First, Middle, Las	st)						2. Date of De.	ath Day	Year	3. Time of Death
an cal	MAURA HAMILT	ion						8	25 2	[a	850 AM
er	4a. Facility Name (If not institution, give	-			4b. City, Town, or		_			nty of Death	
	NEED HOOD HOIDIT		tea		184118V		·	(ro-D)		omic	
	5. Social Security Number 6. S	ex □M 2007F	7. Age (In yrs. Ia 90	St birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bin (Month, Da	v. Year)		place (State or Foreign intry)
	212-12-7455 Usuel Residence of Decedent		90					1-26-19	91/	Mar	cyland
	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
ģ	MD Wicomico Salisbury										1 ☐ Yes 2X No
ire	10e. Street and Number				10f. Zip Code				10g. Citizen o	of What Cou	intry?
Be Completed by Funeral Director	125 Diamond Avenue 21801 USA										
ıner	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S prces?	. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 14. R	ace - Amer lack, White	ican Indian,
y F.	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	2X□ No ve		I ☐ Yes 2∜ ☐ No	Specify:		,,		ity: Whi	
q p	3 Widowed 4 □ Divorced 15. Decedent's Ed	Year or D	ates:	160 Doord	Innt's Havel Ossues	tion					
olete	(Specify only highest gra	de completed)		(Give	lent's Usual Occupa kind of work done o DO NOT use retired	uring mos	t of worki	ng	16b. Kind of	Business/ii	ndustry
m o	Elementary/Secondary (0-12)	College (1-4or 5+)		sperson				Retail	1	
Ö	17. Father's Name (First, Middle, Last)	1			SPECIOIN	18. Mothe	er's Name	(First, Middle,			
To B	Ralph Ober					Lau	ra Gr	een			
_	19a. Informant's Name/Relationship (Туре, Print)		19b. Mailin	g Address (Street a				er, City or Tow	m, State, Zi	ip Code)
	Robert Ober - nephew P.O. Box 676, Greensboro, Maryland, 21639 20a. Method of Disposition 1 \(\mathbb{Z} \) Burial 2 \(\mathbb{C} \) Cremation 3 \(\mathbb{R} \) Removal from State 4 \(\mathbb{D} \) Donation 5 \(\mathbb{D} \) Other (Specify) P.O. Box 676, Greensboro, Maryland, 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gds. 8-28-2007 Hebron, Maryland, 21639										9
											own, State
											yland
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home										
Denise Kelly per dvr 705 E. Main Street, Salisbury, MD 21804)4		
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that o	caused the death. each line.	Do not ente	er the mode of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition Conset and Death									Onset and Death	
	resulting in death)	Due to	(or as a conseque	ence of):							
_	Sequentially list conditions	D.	Norz Fill	1170						1)) (YUE)
edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cha	(or as a conseque	enice ory.	Outon	- 0					1)/-
xar	that initiated events resulting in death) Last	C. Due to	(or as a conseque	ence of):	antwo ind	7 7	11-18	_			30 (0005
aiE											
edic		. 0.									
	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnan		Je				23d. [Date of deliv	very
icia	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregr	ointh 2 □ Fetalo nant at time of dea		Ectopic pregnancy Other (specify)				1	Vionth	Day Year
hys	9 Unknown	9□ Unkn					_				
Completed by Physician/M	Part II. Other significant conditions of			ting in the ur	nderlying cause give	n in Part I	*	23e. Did t	obacco use co		the cause of death?
ted	track contropics.	Loirwa						1 🗀 '	Yes 2□No	3 □ Pro	bably 4 Unknown
pie	MNOUMONIA							24a. Was	an 24I	. Were aut	topsy findings available ompletion of cause of
5	Listory OF Myscarl	liAL In	Laitmar					perio	rmed? 2 □ No	death?	2 No
Be	25. Was case referred to medical examiner?						of Death	Check only	one		
မှ	1 ☐ Yes 2 ☑ No			R/Outpatien		416/NI		ne 5 🗌 Resi			ufy)
tion	27 Manuar of Death 1 Natural 5 Pending 2 Accident investigation		th, Day Year)	28b. Time of Injury	Work	at :? ∕es 2.⊟		28d. Describe	how injury occ	urred	
lica	3 Suicide 6 Could not b	e 290 Place	of Injury - At hon	ne farm str				28f Location (Street and Nu	mher or Ru	ral Route Number,
erti	4 Homicide determined	buildi	ing, etc. (Specify)	,				City or To	wn, State)		
Medical Certification:	29a. Certifier 1 Certifying Ph	ysician: To the	best of my know	ledge, death	occurred at the tim	e, date ar	nd place, a	and due to the	cause(s) and	manner as	stated.
edic	(Check only 2 Medical Exar	niner: On the b	asis of examination of stated.	on and/or inv	estigation, in my or	oinion, dea	th occurr	ed at the time,	date and plac	e, and due	to the cause(s)
ž	29b. Signature and title of certifier				29c. License	number			29d. Date sig	ned (Month	i, Day, Year)
	I Whole H	LAblu	SI		027	527			8-25-1	7004	

s of person who completed cause of death (Item 23a) (Type, Print) JUHLOTTMAN

			Registrar	aryland / Depa	artment of Health and rtificate of Death		ene2007	29462		
в	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death		
	/Medic	al	Shirley Marie Hanf 4a. Facility Name (If not institution, give street and number)	1	4b. City, Town, or Location of Dec		29 2007 4c. County of Deat	2:45 p. M		
	Examin	er	Mallard Bay Care Center		Cambridge	atti	Dorche			
	Funeral		5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year If Under 24 Hi		9. Birt	hplece (State or Foreign untry)		
	Director		218-26-6227 1 M 2X F	77 Yrs.	Months Days Hours Mi	Feb. 21,		ryland		
Γ	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation	•		10d. Inside City Limits		
C	Maryt f sho	to	MD Dorchester		Church Cre	eek		1 ☐ Yes 2√2No		
N	r 28e	Director	10e. Street and Number		10f. Zip Code	g. Citizen of What Co	Citizen of What Country?			
3	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f ehow fre Madical Exemiter musi be mullied at	alD	1621 Perseus Road		21622		USA			
2	tems	Funeral	11. Marital Status 12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White			
36	Ir, or I	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ② If Yes, Give 3 □ ◯ Widowed 4 □ Divorced Year or Dates:	No	1 ☐ Yes 2 ☒ No Specify:		Specify:	white		
21215-0036	2 hou	ted	15. Decedent's Education	16a. Decer	dent's Usual Occupation	16	Bb. Kind of Business/	Industry		
218	thin 7	Completed	(Specify only highest grade completed) Etementary/Secondary (0-12) College (1-4ors	5+)	kind of work done during most of w DO NOT use retired)	rorking				
12	filed w Hygier Sther th		11 17. Father's Name (First, Middle, Last)	S	secretary	ame (First, Middle, Ma	utilit	У		
Maryland	A d a b) Be	Michael Robinson			Marie Bliza				
Z	should I	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or I			(ip Code)		
	1 and 2 Heelth a tam 27 la other trau	6	Betty Harrison p.r.	P. (). Box 127, Church	ch Creek, M	1D 21622			
ore	of Hee		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		natory or other place)		c. Location - City or			
Ē	. Pages Iment of h tant: If its jury or of		4 Donation 5 Other (Specify)	Woodlawn			Baltimore,			
Baltimore,	permit. Pages Depertment of Important: If it any Injury or once.		21. Signatury of Funeral Service Licensee		Name and Address of Facility 700 Locust St., (
	Physician /Medical Examiner	L.	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (on as a consequence of): Save that list condition Phen man.							
	ocuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a onsequence of):						
8760,	ate be executed physicien and the burial-transit	lical Ex	resulting in death) Last Due to (or as	a consequence of):						
9	ing phi	Medi	IF FEMALE:							
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	23b Was decedent pregnant 23c. If yes, outcome	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year		
	requires that been signed should be del	þ	Part II. Other significant conditions contributing to death to Carlot A (+C(4 5+CnOS	out not resulting in the unit $S + H + I$		23e. Did toba	cco use contribute to			
al Records,		Completed	Peptic Ulcer Dise Transient Ischem	ic Attai	Dinal Steno	performe	prior to d	topsy findings available completion of cause of 2 No		
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Othor	eath (Check only one)				
o	Phy this rald	: To	27. Manner of Death 28a. Date of Inju	ent 2 ☐ ER/Outpatien ury 28b. Time of	IL 3 DOA 4 ANUrsing	Home 5 ☐ Residen		cify)		
ion	Attending F r death. sctor: After by the funer	atlor	1 Statural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	y Year) tniury	Work? M 1 □ Yes 2 □ No					
Division	al or Atte efter de: Directo d in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Inbuilding, et	jury - At home, farm, str tc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,		
	To the Hospital or Attenwithin 24 hours efter deati To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner st	of examination and/or inv	n occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the cau curred at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)		
)	To t withi To tl	2	29b. Signature apolitic of certifier D	.0,	29c. License number ## 4 4 6 1	5	Date signed (Monti	n, Day, Year)		
_			30. Name and address of person who completed cause of a	death (Item 23a) (Type,	Branble	St CA	ambrida	e MP		
	Sta Registr		2112	rar's Signature	1		1			
	negistr	वा	AUG 3 1 2007	man St.	April 1					

DHMH 17 Rev 1/2001

ORIGINAL

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ADEEB

MO

AUG 2

JAGER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007▶

100 HOSAITAL RO

32. Registrans Signature

29c. License number

160390

FREDERICK.

29d. Date signed (Month, Day, Year)

2007

			1 - State of Maryland / Depart Certif	ment of Health and Me ficate of Death	ental Hygier Reg. 1					
	Physici		Decedent's Name (First, Middle, Last) Judy Haie		2. Date of Death Month I	Day Year 10:15а м				
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	b. City, Town, or Location of Death Silver Spring f Under 1 Year If Under 24 Hrs. Annths Days Hours Min.		4c. County of Death Montgomery 9. Birthplace (State or Foreign Country)				
	ס	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	ion Spring	10/03/1	10d. Inside City Limits 1 □ Yes 2 및 No				
	3a or 28a-	il Director	10e. Street and Number 10021 Tenbrook Drive	10g.	Citizen of What Country?					
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event. The Medical Examiner must be notified at once.	Completed by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	20901 s Decedent of Hispanic Origin? (Speces, specify Cuban, Mexican, Puerto Ri	fy Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
21215-0036	l within 72 ho iene. r than *natur the Medical i	ompleted	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Give kind life. DO	ts Usual Occupation of of work done during most of working NOT use retired) Chasing Agent	7	Kind of Business/Industry				
Maryland 2	uld be filed Jental Hyg rrked other	To Be C	17. Father's Name (First, Middle, Last) Woodward Judy	(First, Middle, Maiden Sumame)						
, Mary	and 2 sho saith and h n 27 is ma		Hollis Haje/Daughter 1002	21 Tenbrook_Dr.		Number, City or Town, State, Zip Code) Lver Spring, Md 20901				
Baltimore,	. Pages 1 tment of He tant: if Iter jury or oth		20a. Method of Disposition 1 Surial 2 Cremation 3 Regional from State 4 Donation 5 Other (Specify) Fort Lin	oc. Location - City or Town, State Brentwood, Md						
Bai	Depar Impor any Irr		21. Signature, the uneral Service License PHILIP D. RINALDI FUNERAL SERVICE, P.A. 22. Name and Address of Facility PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9.241 Columbia Blvd. Silver Spring, Md20 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infar Due to (or as a consequence of):	respiratory arrest,	Interval Between Onset and Death					
68760,	ficate be executed g physician and ts the burial-transit	edicai Examiner	Securities with the control of the c	5						
P.O. Box 68	The law requires that the death certifics tie has been signed by the attending phage 2 should be detached for use as t	Physician/Med		topic pregnancy ther (specify)		23d. Date of delivery Month Day Year				
	w requires that been signed t should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.		e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown				
al Reco		Completed	OF Was not referred to profite the		24a. Was an autopsy performed′ 1 ☐ Yes 2 🔯					
Division of Vital Records,	Attending Physiclan: or death. ector: After this certifica by the funeral director, i	ion; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ EP/Outpatient : 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury			6 ☐Other (Specify)				
Division	al or Attenders after death	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, building, etc. (Specify)	If. Location (Street City or Town, St	and Number or Rural Route Number, ate)					
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (29a. Certifier (CIRCX only one) Certifying Physician: To the best of my knowledge, death oc and manner stated. Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX only one) Certifier (CIRCX one)	tigation, in my opinion, death occurred	at the time, date a	and place, and due to the cause(s)				
)	\ <u>0</u>	2	29b. Signature and title of certifier 30. Name and a wass of person who completed cause of death (tem 23d) (Typs). Prin	29c. License number D34472		Date signed (Month, Day, Year) August 28,2007				
	Sta	te	Lynn Diggs MD 10400 Connecti	icut Ave. #206	Kensing	ton,Md 20895				
	Registr		AUG 2 9 2007	W.						

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician; fter death. Director After this certifica

Baltimore, Maryland 21215-0036

Certification:

ģ Medical

1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0064801 M.D 30. Name and addres person who completed cause of death (Item 23a) (Type, Print) Bhann Inel 7501 Surratts Rd #307 Clinton, MD 20735

31. Date filed (Month, Day, Year) AUG 3 1 2007 32. Registrar's Signature

Registrar

within 24 hours To the Funeral D

7-06420 hristopher Holi	thau		pe or Print i							egib	le.		
		1- For State	ato or mary		rtificate c		110 1110	ai i iy	giono	Reg. No	20	n.	7 201.6
Physici		Registrar 1. Decedent's Name (First, Midd	le,Last)					1:	2. Date of D	eath		-	B. Time of Death
ledical Exami	ner	Christopher Hi	ller Holt	hcus					Month August	18, 20	O7 Year		2208 hrs
		4a. Facility Name (if not institution Harford Memorial Hos		umber)		4b. City, Town, Havre de		n of Death			c. County of I Harford	Death	
Funeral		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y	ear If Un	der 24Hrs.	8. Date of	Birth (MI	M/DD/YYYY)	9. Birth	place (State or
Director		216-02-1422	1 X M 2 F		36 Yr		ays Hou	urs Min.			F	oreion	Newscad
		Usual Residence of Decedent	122		30 "	<u> </u>			Sep.	10,	1970		NOT ACTE
any		10a. State 10b. County		10c. City	, Town or Loca	ition	,						10d. Inside City Limits
Maryland 28a-f show d at once.	ō	Maryland Harfe	ord	Havi	re de G	race							1 Yes 2 X No
Maryl 28a-f dato	Director	10e. Street and Number				10f. Zip Code	9			10g. C	itizen of What	Count	ry?
ith the Maryland 23a or 28a-f sho notified at once		308 Gedwall Ct.	•			21078			11 1	u.s	.A.	I	
th wit	Funeral	11. Marital Status 1 X Never Married 2 M		cedent Ever in U Forces?		as Decedent of Yes, specify Cul				No-	14. Race - / White, e		an Indian, Black,
er dea			1 Yes	2 💢 No	1	Yes 2 X	No speci	fv:			Specify: (1)	hie	
ors aft	d by	15. Decedent's Education (Spe	Lor Dates:			nt's Usual Occu			ork dòne	16b	. Kind of Busir		
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examine:	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)	during i	nost of working	life. DO NO	OT use retire	ed)				and the second
036 ithin ane.	mpi			3	Pri	nter				P	vintin	g	
5-0 iled w Hygic I othe	_	17. Father's Name (First, Middle					1				n Surname)		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natte event, the Medical Examiner must be notified at once	Be	Jonethan T. Ho.			405 \$4-00	ng Address (Si		11 Rut				01-1-	7:- 0-1-)
and 2 should feath and Me tem 27 is mar traumatte ev	T ₀	Deborch Zavoniji		e-1		(
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is n injury or other traumatte		20a. Method of Disposition	u. Isase		Place of Dispo	8 Gc.dvc.			Date		Location - C		
OFE ges l it of H is If i		1 Burial 2 X Cremation		from State	crematory or o	ther place)	^	081	22 /2A	07 11	os - Ch		on Dá
Baltimore, permit Pages I an Department of Hea Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Project	pecify:	κ.									neral Hone
Balti permit Departm Imports		7 Su (elte	P									10 21078
Physician		23a. Part I. Enter the disease, or failure. List only one cause		caused the death									Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease		ngic fibr	inous pe	ricarditi	s with	massiy	e peri	cardi	al effus	sion	Death
		or condition resulting in death)	Due to (or as	a consequence	of):								
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence	of):								
	mine	cause. Enter Underlying Cause (Disease or injury that initiated	С									_	
13: e & 6	Exa	events resulting in death) Last		a consequence	of):								
Box 68760, the death certificate be executed the attending physician and ed for use as the burial - transit	ical	X UNPENDED	d. AMENDED	TT 07	MT 071	0/15/07							
60, ate be hysici e buris	Med	IF FEMALE:	23c. If yes	211,27,per	ME,g8/1,	9/15/0/	IT			2	3d. Date of de	elivery	
Box 68760, e death certificate be the attending physic of for use as the bur	Physician/Medica	23b. Was decedent pregnant in t past 12 months?	he 1 Live	birth	2 F	etal death	3 Ecto	pic pregnar	псу		Month	Da	y Year
OX (eath co	sici	1 Yes 2 No 9 Un	known 9 Unki	nant at time of d	eath 5	Other (Specify)							
by the check the	Phy	Part II. Other significant condi		to death but not	resulting in the	underlying caus	se given in	Part I.	23e. Di	d tobacc	o use contribu	ute to th	ne cause of death?
Division of Vital Records, P.O. Box 68 teal or Attending Physician: The law requires that the death certif is after death. at Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	l by	Hypertensiy	ve atheroscl	erotic ca	rdiovasc	ular dise	956° C	irrhoei	1	Yes 2	✓ No 3	Proba	ably 4 Unknown
cords, law requir has been s	Completed by						, ,		24a. W				opsy findings available
e law e has ge 2 st	ם				*				pe	itopsy erformed es 2	? dea	ath?	empletion of cause of
Vital Rec ysician: The l his certificate	ပို	25. Was case referred to medica	al			26.PI	ace of Dea	th (Check o		:S Z	140	/ Yes	2 10
Vita hysicia this cer	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA	Other ₄	Nursing	Home 5	Resi	dence 6	Other:	
n of ing Ph After t Tuneral	n: T	27. Manner of Death	28a. Date	e of Injury th, Day,Year)	28b. Time of	Injury 28c. I	njury at Wo	ork?	28d. Descri	be how i	njury occurred	1	
ion tendi- leath. tor: /	atio		ding estigation			1_	Yes 2	No					
ivis or Au after of Direc	Certification:	3 Suicide 6 Cou	ld not be 28e. Pla	ce of Injury - At h	nome, farm, str	eet, factory, offic	e building,	etc.		n (Stree	t and Number	or Rura	al Route Number, City
D espital hours neral / fillec	Cer	4 Homicide dete	ermined (Specify)									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ical	(Check only Certifying P	hysician: To the beaminer:On the basis										
To t with To t	Medical	29b. Signature and title of certifi,	and manner	stated.			ense numb				d. Date signed		
		Data : 1	Ja ~ -	PODA	- 00	l l	C.M.E.				ugust 20, 2		
		30. Name and address of person	who completed car	use of death (Iter	m 23a)								
		Patricia Aronica-Polla		tant Medical		111 Penn	Street, I	Baltimore	e, MD 21	201			
	tate			Registrar's Signat	ture	P. J.	•		•				
Regis	trar	SEP 13	2007	the way	S. S. S. S. S. S. S. S. S. S. S. S. S. S								

ORIGINAL

OCME 2006

	_1	Togota	Certificate of Death		1. No 20				
Physicia /Medica	ın	1. Decedent's Name (First, Middle, Last) Vincenzo Ippoli	to	2. Date of Death Month August	Day 25, 20	3. Time of Death 2007 12:45			
Examine	-31	4a. Facility Name (If not institution, give street and number) 11017 Picasso Lane	4b. City, Town, or Location of Deat Potomac	h	4c. County Mont	of Death tgomery			
Funeral Director		5. Social Security Number 212-68-3231	Months Days Hours Min.		^(ear) 1914	9. Birthplace (State or Foreign Country) Italy			
laryland show ed at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town				10d. Inside City Limits 1			
h with the M 23a or 28a-f st be notifie	Funeral Director	Maryland Montgomery Si 10e. Street and Number 120 Lexington Drive	lver Spring 10f. Zip Code 20901	100	10g. Citizen of What Country?				
Irs a	۵	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	Blac	e - American Indian, k, White, etc. White			
within 72 ho ene. than "natur he Medical b	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of wo fie. DO NOT use retired) Builder	rking 10		ruction			
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) Vincenzo Ippolito	18. Mother's Nar	me (First, Middle, Ma ia Vicini	e, Maiden Surname)				
d 2 shorth and N			Mailing Address (Street and Number or R	·					
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disposition 20b. Place of I cemetery 20c. Method of Disposition 20b. Place of I cemetery	1017 Picasso Lane, Disposition (Name of crematory or other place) Heaven Cemetery	Date ug. 31,	Oc. Location -	City or Town, State Spring, Mary1			
permit. Departm Importa any inju		21. Signature of Funeral Service Licensee Prancis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring							
Physician /Medical Examiner sthe putal-transit	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Finer Under in Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.				Approximate Interval Between Onset and Death			
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Dat Mo	te of delivery .nth Day Year			
es t igne be d	þ	Part II. Other significant conditions contributing to death but not resulting in	ne underlying cause given in Part I.			ribute to the cause of death? 3 ☐ Probably 4 ☐Unknow			
law as b 2 st	Completed				ppsy prior to completion of cause of death?				
Attending Physis death. ector: After this by the funeral dii	25. Was case referred to medical examiner? 1								
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.							
Veithin Comple	Me	29b. Signature and title of certifier. **LIMITED STATES** N. D.**	29c. License number D16619	29	_	d (Month, Day, Year) t 27, 2007			
	_ h	30. Name and address of person who completed cause of death (Item 23a) (T	ma Drint)						

DHMH 17 Rev 1/2001

Tender of Death 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) BABY GIRL JONES 2. Date of Death Month JUL 15 Month 15 4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER BETHESDA 5. Social Security Number 6. Sex 1 Month 1 M	Day Year
Physician /Medical Examiner BABY GIRL JONES 4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER BETHESDA 5. Social Security Number 6. Sex 1 Month 15 4b. City, Town, or Location of Death BETHESDA Funeral 5. Social Security Number 6. Sex 1 Month 15 4b. City, Town, or Location of Death BETHESDA 7. Age (In yrs. last birthday) Months Days Hours Min. (Month, Days) Month Month, Days Month Month, Days Month Mo	^{Day} 2007 Year 12:45 A M
Aa. Facility Name (if not institution, give street and number) Ab. City, Town, or Location of Death	
NATIONAL NAVAL MEDICAL CENTER BETHESDA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Days (Month, Days)	
Funeral 1 M 2 XI F Vs Months Days Hours Min. (Month, Day	MONTGOMERY
Director N/A W 2 kg Yrs. 1 5 JUL 14	Year) 9. Birthplace (State or Foreign Country)
Usual Residence of Decedent	2007 MARYLAND
	10d. Inside City Limits
PRINCE GEORGE'S LAUREL	1 XYes 2 No
10a. State 10b. County 10c. City, Town or Location MD PRINCE GEORGE'S LAUREL 10e. Street and Number 10e. Street	0g. Citizen of What Country?
108 LAUREN DRIVE APT 104 20724	UNITED STATES 14. Race - American Indian,
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Marital Status 15. Was Decedent Ever in U.S. Armed Forces? 16. Yes 2 No 17. If Yes 2 No 18. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 19. Yes 2 No 11. In Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
If Yes, Give 1 ☐ Yes 2 ☐ No Specify:	Specify: BLACK
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A	16b. Kind of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+) N/A	N/A
N S S S S S S S S S S S S S S S S S S S	
JON KARL JONES 17. Father's Name (First, Middle, Last) JON KARL JONES CHEZDA CLAUDETTE	YOUNG
10a. State 10b. County 10c. City, Town or Location 10c. Ci	r, City or Town, State, Zip Code)
CHEZDA YOUNG/MOTHER 108 LAUREN DRIVE APT 104 LAU DO	IREL MD 20724 20c. Location - City or Town, State
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Di	NIMC Bethesda, Ma
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenson 22. Name and Address of Facility NMC Bethesda MD 22. Name and Address of Facility NMC Bethesda MD	7014110
21. Signature of Funeral Service Licenson 22. Name and Address of Facility Name Bethesda MD	
23a. Parl 1. Enter the disease, or lomplications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shirts, or heart failure. List by one cause of each line.	est, Approximate Interval Between
Physician Immediate Cause (Final disease or condition FXTREME PREMATIJR TTY	Onset and Death
/Medical resulting in death) Due to (or as a consequence of): Examiner	
. Sequentially list conditions	
fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
ddi	
The period of th	23d. Date of delivery
FFEMALE: 23c. If yes, outcome pf pregnancy 1 1 yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2	Month Day Year
S the state of th	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	bacco use contribute to the cause of death?
in the second property of the second property	es 2X No 3 Probably 4 Unknown
24a. Was a autop performance of the control of the	sy prior to completion of cause of
Performance of the performance	2 X No 1 ☐ Yes 2 ☐ No
28d. Describe h	ow injury occurred
1 Matural 5 Pending (Month, Day Year) Injury Work? 1 Matural 5 Pending (Month, Day Year) Injury Mork? 1 Mork? 1 Mork? 1 Mork? 2 Accident investigation investigation of Document of Day See Place of Injury - At home, farm, street, factory, office determined the position of Day See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, factory, office 28f. Location (See Place of Injury - At home, farm, street, farm, street, farm, street, farm, street, farm,	
286. Describe in the part of	treet and Number or Rural Route Number, n, State)
	cause(s) and manner as stated.
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number	date and place, and due to the cause(s)
94 H	29d. Date signed (Month, Day, Year)
RES-000	0/[18] 200/
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVA KATE OLIVER LT MC USN BETHESDA MD 2	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar SEP 1 3 2007	

		-	For State Registrar	State of Ma	ryland / [-	rtment of H tificate of L			ental Hy	gier Reg. 1	ne vo. 20 (7	291	469
	Physicia		Decedent's Name (First, Middle, Last)	s Genevie	ve Jack	son				2. Date of De Month	ath [ear	3. Time of 1	Death
	/Medic Examin		4a. Facility Name (If not institution, give s 46 West Cherry St	street and number)			4b. City, Town, or	Location		nagase		4c. County of			,
	Funeral Director		5. Social Security Number 6. Sex 219-28-7713	7. Age	(In yrs. last bit	rthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da Dec.	ay, Yea	ar)	Count	ace (State or y) arylar	
nore, Maryland Z1Z13-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Ceci 10e. Street and Number 1151 Tome Highwa 11. Marital Status 1	12. Was Decedent E Armed Forces? 1	kson 191) 46 20b. Place complete	13. V 1 1 1 Deced (Give life. L) 5 W • of Dispo	Port 10f. Zip Code	L904 lispanic Oan, Mexico specify reation during mod 18. Moth	rigin? (Spean, Puerto /:	e (First, Middle Eva Mo al Route Numl	16b Nar. CNar. 57,	14. Race-Black, Specify: . Kind of Busin Persor den Surname) nee	America White, e	on Indian, tc. White ustry Reside Code) n, MD wn, State	nce 21911
I	Physician /Medical Examiner	dical Examiner	21. Signature of Funeral Service licens 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ications that caused ne cause on each line. Due to (or as a b. Due to (or as a c.		not enter	Name and Address A. Paterryville er the mode of dying the Art of t	, Ma	rylan	d 219	03-	0766	e, P	Approximate Interval Bety Onset and D	veen
P.O. Box 6	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown Part II. Other significant conditions conditions	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal deat time of death	5[∃Ectopic pregnanc ∃Other (specify) _ nderlying cause giv	7	t I.	23e. Did	tobac	23d. Date Mont	h oute to th	Day \	
Vital Records,		Completed b								24a. Wa aut per 1∐ Yes	opsy formed 2 X	24b. W	ere auto	ably 4 □ lossy findings and the properties of calculation of calculations.	available
Division or Vit	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1	Hospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da) 28e. Place of injubuilding, et	y Year) 28b.	Time o	f 28c. Inju	ner: 4	Nursing Ho		sidence how i	e 6 Nother	(Specify		
_	ne Hospital n 24 hours a ne Funeral	edical Co	29a. Certifier 1 ☐ Certifying Phyone) 2 ☐ Medical Exam	/sician: To the best liner: On the basis o and manner sta	f examination a	ge, deat and/or in	h occurred at the ti	ime, date opinion, d	and place, leath occu	, and due to the	e caus e, date	se(s) and man and place, ar	ner as s	tated. the cause(s	s)
)	To th within To th	Me	29b. Signature and title of cartifler	la 8)	m				392	5	29d.	Date signed	Month,	Day, Year)	
	4		30. Name and address of person who of Oliver S. Thresh 31. Date filed (Month, Day, Year)	er, Jr.,	M.D., 9	Que	een Stree	et, R	ising	Sun,	Mar	yland	21	911	
	St Regist	ate trar	AUG 3 1 200	7 Storens	ar's Signature	GOL	uli								

ro the

State Registrar 29b. Signature and title of certifier

Michael 31. Date filed (Month, Day, Year) AUG 3 1 2007

N.

32. Registrar's Sign ture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baako MD 3450 Fort Meade Road # 209 Laurel, Maryland

29c. License number

D0057216

29d. Date signed (Month, Day, Year)

August 30 2007

amend 8,7,9, 17,24a per Dr. 9871 9/13/07 KBH Pléase Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. 12007 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** Karikari -2007 2158 05 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Prince Prince George's Cheverly 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 19 10 M 20/F Yrs. 4/25/07 MD Director none Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 No 2 No TAKOMA PARK by Funeral Director MD MONTGOMERY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20912 USA 6731 NEW HAMBSHIRE AVE 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 📉 No Specify: 3altimore, Maryland 21215-0020 Specify: BLACK 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) INFANT INFANT 0 0 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be KARIKARI SHEILA unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) MOTHER - SHEILA KARIKARI NEW HAMPSHIRE TAKOMA PK MD AVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3001 HOSPITAL ISK 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) KELEASE To CHEVERLY, MI 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility HOSPITAL DR Mutte Proto 20785 CHEVERLY, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physicien end for use es the bunel-trensit the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in deeth) Lest Box 68760. within 24 hours after death.

To the Funerel Director: After this certificata has been signed by the a completely filled in by tha funeral director, page 2 should be detached it P.0. Part JJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy Sudmin 20 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: Medical Certification: To 1 Yes 2 No t □ Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 27. Menny of Death 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 2 Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) or A 4 Homicide To the Hospital within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted.

Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature end title of dertifie 29c. License number of death, (Item 23e) (Type, Print) nta rince Geor 31. Dete filed (Month, Day, Year SEP 13

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Angelo S. Karadimos 2007 7:00 AM 26. /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2787 Trumpeter Court Charles Waldorf If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1**X**]M 2□ F Director 578-36-9980 District of Columbia June 3, 1928 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show a or 28a-f show t be notified at Director 1 ☐ Yes 2 K No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with items 23a 2787 Trumpeter Court 20601 U.S.A. **Examiner must** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 X Married ò 1 ☐ Yes 2 ☑ No þ Specify Year or Dates:1950-1952 3 ☐ Widowed 4 ☐ Divorced natura!", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of the Navy Engineer is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Spiro George Karadimos ဥ Irene Peleki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trae 2787 Trumpeter Court, Waldorf, Maryland 20601 D. Maurine Karadimos - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 8/30/2007 Washington, D.C. 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Severe End Stage Parkinsonism disease or condition resulting in death) 18 years /Medical Due to (or as a consequence of): Examiner Advanced Atherosclerosis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The to for as a consequence of the death certificate be executed y physician and is the burial-tran: Due to (or as a consequence of): Physician/Medical as attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Saknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Kesidence 6 Other (Specify) 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No hours after death. uneral Director: / 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

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within 2

State Registrar

29a, Certifier

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rson who completed gause of death (Item 23a) (Type, Print)

and manner st

rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 29473 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 28^{ay} AUG TOM PATRICK KAUFMAN 2007 13:33P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT 28 1953 9. Birthplace (State or Foreign Country)
NC 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1**M** M 2□ F Hours 220-60-0553 53 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits show rat", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director MONTGOMERY MD POOLESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19813 WESTERLY AVE. 20837 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "naturaf", Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) PROFESSIONAL SERVICE AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental DON RAYMOND KAUFMAN JULIE FILTZ ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra DONNA KAUFMAN / SPOUSE 19813 WESTERLY AVE., POOLESVILLE, MD 20837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MONOCACY CEMETERY 9/1/07 BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, 21. Signature of Funeral Service Licenses 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No 1□ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2□ No 1 Yes 2 FR/Outpatient 3 DOA င္ 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) After this funeral of 28b. Time of 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation within 24 hours aren common to the Funeral Director: Aff 1 🔲 Yes 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the date and place and due to the cause (s) and manner as stated.

| Comparison of the date and place and due to the cause (s) and due to 29a. Certifier Medical and manner stated. 29c, License number 29b. Signature and title of certifier 00064068 ino 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical Courter Drive Kalana Rockville Manyland 31. Date filed (Month, AUG 3 1 State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29474 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month 12:55 AM Helen Elizabeth Keilholtz August 30, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth July 13, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 81 Mary land 214-34-1013 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits Maryland | Frederick 1 Tyyes 2 □ No Thurmont 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 149 North Carroll Street 21788 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen George Norman Stevens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. Keilholtz, Jr./Son 13720 Graceham Road Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 9/4/2007 Frederick, MD Resthaven Mem Gard 22. Name and Address of Facility Stauffer Funeral Home, PA 104 E. Main Street, Thurmont, MD 21788 23a. Part1. Enter the disease, or complications that caused the death. Do not not the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown

Physician /Medical **Examiner**

physician

Physician

/Medical

Examiner

Funeral

Director

Show

ms 23a or 28a-f show

7 Is marked other than "natural", or items traumatic event, the Medical Examiner man

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If fem 27 is marked other transmit any injury or other traumatic event.

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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that the death certificate be executed P.O. Box 68760.

Division or Vital Records,

ne Hospital or Attending Ph n 24 hours after death. ne Funeral Director; After ti

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	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
13	Part II. Other significant cond
	25. Was case referred to mediexaminer?
	27. Manner of Seath 1 Natural 2 Accident 3 Suicide 4 Homicide

Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ical 1 Inpatient Date of Injury ding estigation

autopsy 26. Place of Death (Check only on

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of

ıld not be ermined

2 ER/Outpatient 3 DOA (Month, Day Year)

28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature ap

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of pers Robert Kaufmann eted cause of death (Item 23a) (Type, Print)

gistrar's Signatu

West Ninth Street Frederick,MD 21701

State Registrar

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	Physic	an	Decedent's Name (First, Middle, Language)	ast)				Month	ath Day	Year	3. Time of Death
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	Examir	ner	4a. Facility Name (If not institution, gi 2009 Owens Road	e street and number)		4b. City, Town, or Oxon Hill	Location of Death		4c. County		
	Funeral			Sex 7. Age	(In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	9. Birth	place (State or Foreign
В	Director		110-10-9273	¹ □M 2 ⊠ F 8	9 Yrs.	Months Days	Hours Min.	(Month, Da) Dec. 20	y, Year)	Cou	ntry) York
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	Maryla f shored at	5		Cooraca							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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	ems :	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		- Ameri	can Indian,
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Б	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Las	")			18. Mother's Name		Maiden Surnam	e)	
<u>y</u> la	ould l	၉	Jacob Tikalsky				Bella Za				
Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship		1	ing Address (Street a					
ē,	Healt Healt tem 2		Zachary Leiner 20a. Method of Disposition	(Son)	20b. Place of Disp	Lake Blvo	i	Date V	irginia 20c. Location -		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		*	matory or other plac rat Cemet	i i	R /07		•	
Ħ	mit. F Dartm Dortar Injur		21. Signature of Funeral Service Light	•		2. Name and Addres			Funeral		, New York
m	and in the part		Kover	-E. E18		755 Castle		rive, A	lexandri	a, V	VA 22315
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each line	the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition	Aspirat	ion pneumo	onia					Onset and Death 3 days
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
(i) (i)	- B	J.	Sequentially list conditions,	U.	dementia					-	5 years
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oʻ.	exect an and rial-tra	Еха	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):						
68760,	ficate be executed physician and s the burial-transit	edical		_ d							
_	ertifica ing ph e as th	Med	IF FEMALE:			-					
Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p	2 ☐ Fetal death 3[Ectopic pregnancy			23d. Date Mor		ery Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of death 5 L	Other (specify)			11101		July 1001
	w requires that the de been signed by the should be detached	/ Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to t	he cause of death?
rds	quires n sigr ld be	d by	Hypertension					1 🗆 Y	′es 2⊠ No	3 ☐ Prol	bably 4 ∐Unknown
Records,	aw re is bee 2 sho	Completed						24a. Was a		ere auto	ppsy findings available
ž	: The law cate has I	lmo							rmed? d	eath?	mpletion of cause of
Vital	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deatl		75		2010
2	Physic this coral dire	P.	1 ☐ Yes 2 🔼 No	Hospital: 1 Inpatier			4 ☐ Nursing Ho		lence 6 🗆 Othe		fy)
Division or	ding F h. After funera	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		Work		28d. Describe h	ow injury occurre	ed	
200	or Attencate death Director:	ficat	2 Accident investigatio 3 Suicide 6 Could not b	9	ry - At home, farm, str		Yes 2□No	28f Location (S	Street and Numbe	r or Run	al Route Number,
2	al or A s after Il Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	, ,,		City or Tow	n, State)	, or riar	ar route warmer,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier 1 Certifying Pl	nysician: To the best of miner: On the basis of	f my knowledge, deat	h occurred at the tim	ne, date and place,	and due to the	cause(s) and mar	nner as s	stated.
	the H nin 24 the F	Medical	oney	and manner stat	ed.			red at the time, o	date and place, a	nd due t	o the cause(s)
	Vity CO CO	2	29b. Signature and title of certifier	\Diamond		29c. License		2	29d. Date signed	(Month,	Day, Year)
				Sun		01010	20675		August 2	9, 2	2007
ΛŽ	-(1)		James Sipes, MD		ath (Item 23a) (Type, epy Hollov	·	alle Chur	ch. Vir	oinia 22	044	
	Sta	te	31. Date filed (Month, Day, Year)	20 Pogiatro	da Cianatura		TTO OHUL	VII VIL	51111a 22	V + +	
	Registr		AUG 3 0 2007	See D.	Speck						

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: 24 hours after death Funeral Director; filled in by

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29b. Signature and title of certifier disamago. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

and manner stated.

OXON HILL ROAD STE 500, OXON HILL IND 20745 OSIA 6192

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only

Medical

AUG 2 9 2007



Registrar

Division or Vital Records, P.O. Box 68760,

State Registrar

5851 Deale Murchton 31. Date filed (Month, Day, Year) 32. Registra Signature AUG 2 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

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29d. Date signed (Month, Day, Year)

2007

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	Physicia /Medic		Decedent's Name (First, Middle, Last) Thomas	Warren		Pinkney	,	2. Date of Death Month August	25, 20°C	3. Time of Death 21:26p M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give s Southern Maryla 5. Social Security Number 216-14-5853	nd Hospital	last birthday) Yrs.	4b. City, Town, or L Clintor If Under 1 Year Months Days	1	8. Date of Birth (Month, Day, 03/15/	Year) 9.	eath Corges Birthplace (State or Foreign Country) ryland
2.	70	_	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		,Town or Lo	cation		03/13/	1921 Ma	10d. Inside City Limits 11√2 Yes 2 □ No
	n with th 3a or 24 st be no	al Directo	10e. Street and Number 12601 Van Brady	Road		10f. Zip Code 20772		10	g. Citizen of What USA	Country?
5-0036	i within 72 hours after death with the Maryland liene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral		12. Was Decedent Ever in U. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1944	S. 13. 1 -46	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - A	merican Indian, /hite, etc. Black
0-61212	within lene. than " he Med	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Deced (Give life. I	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of worki	ng	6b. Kind of Busine oard of	Education
and 2	filed Hyg int,	ge	17. Father's Name (First, Middle, Last)				18. Mother's Name			
Maryla	2 should be and Mental is marked o aumatic eve	P	George 19a. Informant's Name/Relationship (Ty)		Pinkne 19b. Mailir	⊇ y ng Address (Street ar	Lena nd Number or Rura	al Route Number,		Skinner e, Zip Code)
	es 1 and 2 of Health a i item 27 is r other tra		Ralph W.Pinkney 20a. Method of Disposition 1X Burial 2 Cremation 3 CR	emoval from State	lace of Dispo emetery, crei	sition (Name of matory or other place)	ate 2	0c. Location - City	•
Baltimore,	permit. Page Department Important: If any injury or		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		22	2. Name and Address	of Facility Ad	ams Fur	eral Ho	am,Maryland ome PA yland 20608
68760,	death certificate be executed Wedical Wedical Fixam dor use as the burial-transit After the	edical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Annual Control of the	uence off:		, such as cardiac o		st,	Approximate Interval Between Onset and Death
O. Box 6	death certiff e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 8 \(\text{Ulknown} \)	3c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
rds, F.	The law requires that the dite has been signed by the rage 2 should be detached	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause giver	ı in Part I.	23e. Did toba	4	e to the cause of death?] Probably 4 ☐ Unknown
Vital Records,	The lay ate has page 2	Completed							ed? deat	
DIVISION OF VIT	ending Phy sath. or; After this the funeral d	Certification: To Be	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of injury - At hobididing, etc. (Specifications)	ER/Outpatier 28b. Time or Injury	Other Other	at es 2 \(\sum \text{No} \)	me 5 Resider 28d. Describe how	nce 6 Other (& vinjury occurred	Specify) r Rural Route Number,
1	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by 3	edical Cer	29a, Certifier (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat	h occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the ca red at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier	2		29c. License	number	29	d. Date signed (M	onth, Day, Year)
			30. Name and address of person who co	moleted cause of dooth (them	23a) /Timo	D 30	7691		7/28	107
4	B		Bahram Red	ace 446'	70181	ranch Av	e#201	Temp	le Hill	5 mg 20748
.5	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 9 20	32. Jegistrar s Sigila	& So	arle				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2007 29480 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 28,20°07 Polen Nancy August 6:15a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month Day Year) 3/11/1920 9. Birthplace (State or Foreign Country)
Maryland 6. Sex **Funeral** 1 ☐ M 2 🖫 F 87 220-09-5830 Yrs. Director Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f ahow other than "natural", or items 23a or 28a-f ahor vent, the Medical Exercit or must be neutified at Silver Spring MD Montgomery Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 USA #201 601 East Randolph Road 238 Funerai filed within 72 hours after death items : 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) I ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify Specify: Completed by 3 □ Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 of Heelth and Mental Hygis I Item 27 is marked other I r other traumatic event, II 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Heelth and Mental Hy Important: If Item 27 is marked oth any liqury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Surname) Be Fitzpatrick Frances Charles Gogel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1337 Crockett Lane Silver Spring, Md 20904 Wendy Wexler/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Aemoval from State Chesapeake Crem. 8/29/2007 | Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service License PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** <u>Cardiac Arrest</u> /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown has been signed b ge 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Coronary Artery Disease 1 ☐ Yes 2X No 3 Probably 4 Unknown Be Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page COPD 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 🙀 No 2 ER/Outpatient 3 DOA Sign Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. investigation 1 Tes 2 No 2 Accident d in by the 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a
To the Funeral C
completely filled i filled Medicai 29a. Certifier 1 XCartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 D0065485 suparich 18m MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Supanich MD 1500 Forest Glen Rd. Silver Spring, Md 20910 Barbara 31. Date filed (Month, Day, Year) AUG 2 9 ∰egistrar's Signature State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 29481 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 16:25 ₽M Lena B. Piatt August 29 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Union Hospital of Cecil County Elkton If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M XXXF Yrs Director 78 281-26-0657 18, 1929 Ohio Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location fshow 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 ∐ Yes 2XXNo Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 45 Pinder Avenue Funeral 21921 United States death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White **6** 3 Midowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi Department of Health and Men Important: If item 27 is marker any Injury or other traumatic Pages 1 and 2 should Walter C. Harris Amanda S. Dearth ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27407 Brenda L. Simpson / Daughter B130 Alamance Church Road, Greensboro, NorthCarolina 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1√Burial 2 □Cremation 3 □Removal from State 4 □Donation, 5 □ Other (Specify) North East Methodist 1, 2007 North East, Maryland 22. Name and Address of Facility Crouch Funeral Home 21. Signatur of mer Service Licens 127 South Main Street, North East, Maryland 21901 23a. Fart1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PULMONARY EMBOLUS 0445 /Medical Due to (or as a consequence of): Examiner LETASTATIC LUNG Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed CHRONIC OBSTRUCTIVE PULMONARY burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2☑No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 10 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11554000 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite #3 ELKTON MAKYLAND 21921 VD DAVID GAR-EL 304-306 North 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For Amend 25,27,28a-	State of Ma f,perME,g872	aryland 2,10/23	/ Depa /07 <i>Ce</i> /	artment <i>rtificate</i>	of H	ealth ai Death	nd Mental H	lygiene Reg. No.	7007	291	.82
	Physicia		Decedent's Name (First, Middle, Last ROBERT		JR.					2. Date of Month AUGUS	Day	2007	3. Time of 6:00	Death M
	/Medic Examin		4a. Facility Name (If not institution, give Washington Advent	ist Hospi				coma	Location of Park	Death	4c. C	ounty of Death	у	
42 	Funeral Director		5. Social Security Number 421-22-1269 Usual Residence of Decedent	x 7. Ago XM 2□F 7	e (In yrs. las 9	Yrs.	Months	Days	If Under 24 Hours	Min. (Month,	Day, Year)	Coun		r Foreign
	filed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural"; or items 23a or 28a-f show ith the Medical Examiner must be notified at	Director	10a. State 10b. County MD Montgome 10e. Street and Number	ry		rown or Lover Sp		Code			10g. Citize	en of What Coun	od. Inside Cit 1 ☐ Yes try?	
õ	be filed within 72 hours after death with the Marylan tall Hygiene. diethey flan "natural", or items 23a or 28a-f show after the Medical Examiner must be notified at	Funeral	1000 Daleview Dr. 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 12 Yes 2 1 N If Yes, Give Year or Dates:					spanic Origi n, Mexican, Specify:	n? (Specify Yes or Puerto Rican, etc.)	No- 14	USA 4. Race - America Black, White, e	etc.	
215-0036	thin 72 hours e. an "natural", Medical Exa	Completed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Edu (Specify only highest grade) Elementary/Secondary (0-12)	cation	1953	16a. Deced (Give life. L	dent's Usual kind of work DO NOT use	l Occupa k done d e retired)	ation	of working	16b. Kind	B L	•	
Maryland 21		Be	17. Father's Name (First, Middle, Last) Robert Pryor, Sr.	2yrs		Cler	ВУ			s Name (First, Midd		Church c	f Love	2
	12 shou h and M 7 Is mar rraumat	To	19a. Informant's Name/Relationship (To Emma Pryor/Daught			613 I	E Stre	eet,	nd Number	or Rural Route Nui Vashingto			Code)	
altimore,	permit. Pages 1 and Department of Healt Important: If Item 27 any injury or other 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens			nwood	sition (Nam natory or oth Cemet	ery	9-	Date -4-2007	Wash	ington,		
g Pa	permit. Departm Importa any inju		23a. Part. Enter the disease, or comp	Shall ications that caused	the death.	42	217 9t	h St	t. N.V		ngton,	DC 2001	1 Approximate	3 Waan
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as Due to (or as Due to (or as	TIC a consequer TE a consequer	nce of):		Ro	EN	TERI			Onset and D	Death
8/00,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as A C U	a conceduo	nce of).				RYF				
.O. DOX 0	at the death certific by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	pf pregnanc 2 □ Fetal de	y eath 3□	Ectopic pre Other (spe	egnancy ecity)	CERTIFORM	R C - A A A A A A A A A A A A A A A A A A	23	d. Date of delive	*	'ear
ecords, P	law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions co	ntributing to death bu	ut not resulti	ng in the ur	nderlying ca	use giv	in Part I.		id tobacco us	e contribute to th	e cause of de	
<u>r</u>	The ate his page	Completed	25. Was case referred to medical						26 Place	24a. W au pe 1 Ye of Death (Check on	utopsy erformed? s 2 K No	death?	osy findings anpletion of ca	
Ö	Attending Physician: r death. ector: After this certific by the funeral director,	ation: To Be	examiner?	1 🖾 Inpatie 28a. Date of Inju (Month, Day	ry 2: / Year)	R/Outpatien 8b. Time of Injury	t 3 DO/	Bc. Injury Work	r: 4 🗆 Nurs	sing Home 5 R	,,)	
_	oital or urs afte eral Dir	al Certification:	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier 1 ☒ Certifying Phy	28e. Place of injubuilding, etc. unk. sician: To the best	of my knowle	edge, death	n occurred a	at the tim	ne, date and	28f. Location City or	n (Street and Town, State) he cause(s) a	Number or Rura	ated.	
)	To the Hosp within 24 hor To the Fune completely fi	Medical	(Check only 2 ☐ Medical Examone) 29b. Signature and title of certifier Auch auch as 24	and manner sta	examination at the desired.		200	License	number	955	29d. Date	signed (Month, L)
2	1		30. Name and address of person who co	ompleted cause of de	eath (Item 2	3a) (Type, I	Print) PA					30-2007 IER PI IBELT	KWY M.D	2072

State Registrar

31. Date filed (Month, Day, Year)

AUG 3 1 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 31 2007 /Medical Earl Deitrick Renner 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital
5. Social Security Number 6. Sex 7. A Hagerstown funder 1 Year | If Under 24 Hrs. Washington 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Hours Min. Director 27, 1925 Maryland 220-16-3462
Usual Residence of Decedent 81 death with the Maryland 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits show at 1 Yes 2 No "natural", or items 23a or 28a-f shedical Examiner must be notified Director Maryland | Washington Hagerstown 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 17812 Sherman Ave. 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ⊠Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: <u></u> Specify: 3 ★Widowed 4 Divorced White Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " vent, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Sheetmetal worker Metal industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental H Lillian Deatrich Renner Harry Renner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Terry A. Renner/son 17812 Sherman Ave. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 9/2/2007 Smithsburg, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Resthaven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sulmonou **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Pancseofic concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as sate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 No the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 **1**0 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 2 ER/Outpatient 3 DOA this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation 1 Natural 1 □ Yes 2 □ No hours after death. death. 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 31 2007 30. Name and addgess of person who completed cause of death (Item 23a) (Type, Print) Hagerstown 05H OT1 Antie East St Ira 31. Date filed (Month, Day, 32. Registrar's Signature State 4 2007 Registrar

			1_ State	partment of Health and M ertificate of Death		2007 20101
			Registrar 1. Decedent's Name (First, Middle, Last)	erinicale of Death	Reg. N	3. Time of Death
	Physici /Medic		George Wesley Ray			Day Year
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	9	М	74 Sheckells Road	Huntingtown		Calvert
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	Months Days Hours Min	8. Date of Birth (Month, Day, Yea 11/22/19	
1940	pu ,		Usual Residence of Decedent	Location	11/22/1	
	faryla shov	ō				10d. Inside City Limits 1 ▼ Yes 2 □ No
	r 28a-i	Director	MD Calvert 10e. Street and Number	Huntingtown 10f. Zip Code	10g. (Citizen of What Country?
	th with	a D	74 Sheckells Road	20639		USA
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by Fi	1 Married 2 Married 1 Married 1 Married 3 Midowed 4 Divorced 1 Married 1 Ma	1 ☐ Yes 🌠 No Specify:		Specify: Black
21215-0036	72 hou natura Ical E		15. Decedent's Education 16a. De	cedent's Usual Occupation ve kind of work done during most of working	16b.	Kind of Business/Industry
21	be filed within 72 ho ntal Hygiene. ed other than "natul event, the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)		S. Government
777	e filed wall Hygiel other the		11 Phar 17. Father's Name (First, Middle, Last)	meceutical Tech	(First, Middle, Maid	
Maryland	nd 2 should be f lith and Mental b 27 Is marked of r traumatic eve	To Be	Thomas Rav		se Jones	•
lary	and N and N Is man		19a. Informant's Name/Relationship (Type. Print) 19b. M.	ailing Address (Street and Number or Rura	l Route Number, City	y or Town, State, Zip Code)
∑,	s 1 and 2 if Health item 27 I other tra			Sheckells Road,		
or or	ages 1 int of H : If ite		IN Burial 2 Cremation 3 Hernoval from State	rematory or other place)		Location - City or Town, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once,		4 □ Donation 5 □ Other (Specify) Chelte: 21. Signature of Fugeral Service Licensee	man vecs.		eltenham, MD
Ba	permi Depar Impor any ir			PO Box 430, Dunk	ymona-wo irk, MD	od F.H., P.A. 20754
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ic heart dis	earl	
	Examiner		Harris to	f		
	D is	iner	Sequentially list conditions, if any, leading to immediate could. Enter Uner Mila Cause (Disease or injury	11.50		
	xecute and Il-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last c			
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical E	d			
မှ	nrtificate ng phys as the	Medi	IF FEMALE:			
Вох	leath certific attending p	lan/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death	B Ectopic pregnancy	4	23d. Date of delivery Month Day Year
O.	the de	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)		ŕ
S, P	The law requires that the dite has been signed by the age 2 should be detached	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ord	requir een si nould l				1 🗌 Yes	2 No 3 Probably 4 Unknown
Division or Vital Records,	e 2	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
tal		ပ္ပ	25. Was case referred to medical	26. Place of Death	1 Yes 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
<u> </u>	Physician: this certificaral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Othor		6 □Other (Specify)
n 0			27. Manner of Death 10至Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injure	of 28c. Injury at 2 Work?	8d. Describe how in	
isio	or Attending after death. Director: After in by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm,	M 1 ☐ Yes 2 ☐ No	Rf Location (Street	and Number or Rural Route Number.
Οį	al or A s after al Direct	Certification:	4 ☐ Homicide determined building, etc. (Specify)	and the state of t	City or Town, Sta	
	To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, a investigation, in my opinion, death occurred	and due to the cause ed at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the Complet	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
	F > F 0		I yuna M. Jagani uf	D005508	83 81	24/07
1	111		30. Name and address of person who completed cause of death (Item 23a) (Typ	ath occurred at the time, date and place, a Investigation, in my opinion, death occurred 29c. License number 0.05508 e, Print) Ada 0.24	1111	
)TI Sta	te	31. Date filed (Month, Day, Year) 32. Registra's Signature	- 10 Ca	646	
	Registr		AUG 2 7 2007 Menue. D	Grantes		

07-06518 Alex Rodriguez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007	29485
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		I- For State Registrar					Certific	cate of	Death					Reg. No).	20		2948
	Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year										ne of Death 27 hrs							
edical Exami		4a. Facility Name (ımber)		4	b. City, To	wn, or L	ocation of		August 2		c. County	of Deat		27 1110
		Fort Washi				,			Fort W	ashing	gton				Prince	Georg	e's	
Funeral		5. Social Security I	Number	6. Sex		7. Age (In	yrs. last b	irthday)	If Under	_	If Under Hours	Min	8. Date of I	,	//DD/YYY	Y) 9. Bi Forei		(State or
Director		228-61-896	O	1 X M	2 F		16	Yrs.		Days	Hours	MIII.	07/02/	1991			ountry)	VA
. A		Usual Residence of 10a. State	f Decedent 10b. County			1100	City Tow	n or Locati	on				10d. Inside City L					nside City Limits
l ow any		MD	CHARLE				•	DIAN HE									1 X	Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Nu			·				10f. Zip (Code		-		10g. Ci	tizen of W	/hat Cou		
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eath with the items 23a ust be noti	eral	11. Marital Status	•		12. Was Dec		in U.S.		s Deceden es, specify				cify Yes or		14. Rac			dian, Black,
r death or ite	Funeral	1 X Never Marri		Married	1 Yes	2 X	No										MATEC	
rs after ural", miner	<u>6</u>	3 Widowed			Yes, Give Yea r Dates: highest grad		ed) 16a	a. Deceden	Yes 2		specify:D			16b.	Specify. Kind of E			
2 hour	Completed	Elementary/Sec			College (1		-		ost of work								1 .	HAU HE
036 ithin 7 ne. r than	힅	10							STUDEN	IT _						NONI	3	
5-0 iled w Hygie I othe		17. Father's Name		e, Last)						1			irst, Middle		n Surnam	ne)		
21215-0036 hould be filed within 72 hours afte nd Mental Hygiene is marked other than "aatural", tife event, the Medical Examiner	o Be	ANIBAL ROD		shin (Tyn	e Print)		11	19b. Mailing	Address				CNILLA		City or To	wn. Stat	e, Zip C	ode)
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Maryland lygiene. The anti-file of 1 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	Ĕ	ANIBAL ROD					36.	3A POP										,
ore, ML ss 1 and 2 s of Health a If item 27 her traums	- 1	20a. Method of Dis			1			e of Dispos		e of cem	etery,		Date	200	. Location	- City c	r Town,	State
MOP Pages ent of int: 11		1 X Burial 2			Removal fr	rom State		OF PEA	ŒŒ				/2007	- 1	CHANI		-	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than injury or other traumatic event, the Medical		21. Signature of Fi	uneral Servic	e License		C. Li	Zalinh	22. N	lame and	Address	of Facility	THORN	ION FU DIAN H	NERAL	HOME	. P.		
		LYDIA C. T				aused the	death Do	not enter the	be mode of	NGSIC f dving s	IN KUA	D, IN	DLAN H	EAD, arrest. s	MAKYL hock, or h	AND A		roximate Interval
Physician /Medical		failure. List or	nly one caus	e on each	ı line.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ocain. Bo	THOU STILLS I	10 111000	· •,g, •								ween Onset and Death
xaminer		Immediate Cause or condition result			anging ue to (or as a	a conseque	nce of):			_			_					
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760, icate be of physicia the buria	Medical	IF FEMALE:			#1.per			1 <u>5/07 </u>	[T	_				2	23d. Date	of delive	ery	
		23b. Was deceden past 12 month		the	1 Live I	birth		2 Fe	tal death		Ectopic	pregnan	су		Month		Day	Year
Box e death of the attenued for us	Physician	1 Yes 2	No 9 U	nknown	9 Unkn	nant at time nown	or death	5 Ot	her (Spec	ify)				9				
£ > £		Part II. Other sign	nificant cond	itions c	contributing t	to death bu	t not resul	ting in the t	underlying	cause gi	iven in Par	rt I.						use of death?
, P.O res that to signed b	d by																	4 Unknown
rds v requi s been should	lete													itopsy		prior to	comple	findings available tion of cause of
Recc The lav cate ha	Completed													erformed es 2		death?		2 No
rifi ii.	Be C	25. Was case reference examiner?	rred to medic		spital:					- 1	of Death (Other		-					
f Vita Physician er this cer	2	1 ✓ Yes 27. Manner of Dea	2 No			Inpatient e of Injury		b. Time of		<u>س</u>	y at Work	_	Home 5 28d. Descri		idence 6		er:	
	ion:	1 Natural		nding	FOUNT	h, Day,Year) D:	F	OUND:	,.,		'es 2 🗸	19	Subject h					
Division tal or Attendirs after death. al Director:	ficat	2 Accident 3 Suicide	parent	estigation uld not be	28e Plac			000 hrs , farm, stre	et, factory,	office b	uilding, etc	c. 2				nber or I	Rural Ro	oute Number, City
Divis Hospital or At 44 hours after d Funeral Direct tely filled in by	Certification:	4 Homicide		termined		Single	Family	′				3	North Po	n, State) pular L	ane, Indi	an Hea	id, MD	
		29a. Certifier 1	Certifying Medical Ex	Physician	n: To the be	est of my kn	owledge,	death occu	rred at the	time, da	te and pla	ice, and o	due to the d	ause(s)	and mann	ner as st	ated.	e e (e)
To the Hos within 24 h To the Fur	Medical	27		. a	and manner	stated.	ation and/o	or investiga			e number	cuired at	trie time, u		d. Date si			
	2	29b. Signature an	a title or certi		1	\triangle			250	O.C.1					ugust 2			ay, i car)
		30. Name and add	tress of norm	on who co	elle moleted car	Ise of death	(Item 23	a)										
181		Laron Lock			nt Medica		iner 1	a) I11 Penr	n Street,	Baltin	nore, M	D 2120)1					
	tate	31. Date filed (Mo	nth Day Yea	9 2	007 ^{32. R}	gistrar's S	Signature	, ,										
Regis	trar				001	Globor			ale	,						-		
DHMH 17 Rev 1/2	2001		DOME					ORIGINA	L									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month a^{M} Evelyn K. Rebhan 2007 August 28 7:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Apr 13 1915 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 N Hours Director 212**-**07-9512 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Carroll New Windsor MD Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21776 9406 Oak Orchard Ct USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: 3 ∰Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Own Home Homemaker 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Julia Feeney William Vick ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 Lorraine Dr Finksburg, MD 21048 Veronica Schwartz/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 08/31/2007 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lakeview Memorial Pk Sykesville, MD 21. Signature of Funeral Service Licenses Pritts funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Odcey disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 🔼 No

24a. Was an autopsy 1∐ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of eath

Hospital: 28a Date of Injury (Month, Day 5 Pending investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28h Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Bother (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural 2 ☐ Accident

3□ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier The Carlo

6 ☐ Could not be

HOMAS

determined

29c, License number D3166C

1 Yes 2 No

29d. Date signed (Month, Day, Year) 8 29 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21157 291 STUNER AVENUE WESTMINGER MANYAL

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

GAWW IIIM

certificate

funeral

Director; /

within 24 hours a

WJL 3

Be

P

Certification:

Medical

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** LOBINSON NIDA 24 14:20 07 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CENTER GEORGES Cheverly PRINCE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2 F 69 231 48 1843 Director 414/38 WASHINGTON, DC Usual Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at XIX Yes 2 No Director MD PRINCE GEORGES LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2240 BRIGHTSEAT ROAD #201 20785 UNITED STATES permit. Pages 1 end 2 should be filed within 72 hours after death a Deportment of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23s any Injury or other traumatic event, the Mental Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married XX Married Maryland 21215-0020 1 ☐ Yes XIX No Specify: Specify: \$ BLACK 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH MARKETING CLERK PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LESLIE SAMUEL HARRIS ပ္ NIDA ESTELLE JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PENNY TRUEHEART / DAUGHTER 5623 FISHER ROAD TEMPLE HILLS, MD 20748 altimore, 20b Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL CEM. 9/1/07 SUITLAND, MD ature of Funeral Service Licensee 22. Nama and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Myocardial Infarction Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner The law requires that the death certificete be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be deteched for use as the buna Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 21 10 1 Tyes 1 ☐ Yes 2 ☐ No nours efter death.

neral Director: After this certificative filled in by the funeral director, p Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 TER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Injury at Work? or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours e 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person pleted cause of death (Item 23a) (Type, Print) CHEVERLY, MD 20785 ttkham-Ebrahimi 3001 HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

AUG 3 1 2007

			1 - State of Maryla Registrar	nd / Depa <i>Cei</i>	artment of F rtificate of	lealth and M Death	lental Hyg	iene _{eg. No.} 20	107	29488
7	hysicia /Medic		1. Decedent's Name (<i>First, Middle, Last</i>) Jose V. Ramirez				2. Date of Deat Month August	h	0 ^{Year}	3. Time of Death 5:45a M
	xamin	~	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital			r Location of Death na Park		4c. County Mon	of Death	ry
	neral ector		5. Social Security Number 6. Sex 1. Age (In yr. 1.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 04-04-1	930	9. Birthpl E1 S	lace (State or Foreign try) alvador
Maryland	-r snow fled at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. C Maryland Montgomery	City, Town or Lo	ocation oma Park				10	0d. Inside City Limits 1X1Yes 2 □ No
th with the	23a or 28a Ist be noti	al Director	10e. Street and Number 7512 Glenside Drive		10f. Zip Code	20912	1	og. Citizen of N		try?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	al', or items Examiner mi	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:			lispanic Origin? (Spean, Mexican, Puerto			ce - America ck, White, e	
21215-0036 d within 72 hours af giene.	tnan -natur he Medical I	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work d)	ing	16b. Kind of B		Ť
land 2	ked other ic event, t	To Be Co	17. Father's Name (First, Middle, Last) unknown	TRAINE	enance we	18. Mother's Name	e (First, Middle, M ina Rami		ne)	
, Maryland and 2 should be file	n 2/ IS mar er traumal		19a. Informant's Name/Relationship (Type. Print) Marta Marquez/Daughter	7512 Takom	Glenside a Park, N	and Number or Rura Drive Maryland,	al Route Number,		State, Zip	Code)
Baltimore, permit. Pages 1 ar Department of Hea	tant: in iten ijury or oth		4 □ Donation 5 □ Other (Specify) G	ate of	osition (Name of matory or other place Heaven Ce	em. 00-2	27 - 07 s	ilver S Mai	Spring rvland	§ ,
Danie Dermit	any in	5 5	Occorded C. Dates	CC361 3	447 14th	Street, I	N.W. Was	hingtor	l Home	C. 20010
Exan	dical niner	ner	23a. Part1. Enter the disease, or complications that caused the deschock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying	equence of):	er the mode of dyir	ng, such as cardiac (or respiratory arre	est,		Approximate Interval Between Onset and Death
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Box	for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of	tal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>	/		1	te of delive	ry Day Year
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	rector, page 2 sh	Completed	OF Was ages referred to medical					y ned? No	prior to con death?	osy findings available inpletion of cause of 2 N No
ysicia ysicia	directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	er: 4 ☐ Nursing Ho	me 5 ☐ Reside		er (Specify	<i>(</i>)
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DIVIS	lled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury · At building, etc. (Spec	cify)			28f. Location (Str City or Town	, State)		
DIVISION Or VITA To the Hospital or Attending Physician: within 24 hours after death.	mpletely fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my ki (2 Medical Examiner: On the basis of examinand manner stated. 29b. Signature and title of certifier	nowledge, deatl	h occurred at the tir vestigation, in my c	ppinion, death occur	red at the time, da	ate and place,	and due to	the cause(s)
D in E	: s n		· Clading	Mo	06	3839	4	9d. Date signe	23/C	Jay, rear)
R () Sta	te	30. Name and address of person who completed cause of death (Ite The Palma Chicumanilla 31. Date filed (Month, Day, Year) 32. Registrar's Sign	7600	Carroll A	venue Ta	ikoma Pai	rk, Mar	/ yland	20912
R	egistr		31. Date filed (Month, Day, Year) AUG 3 0 2007 Server 6.	opera						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 7 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0615 ASMUSSEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mandrin Chesapeake Hospice House Anne Arundel Harwood If Under 1 Year 8. Date of Birth (Month, Day, June 20, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex **Funeral** Months Days Hours Min. 1 □ M 507-54-8531 65 1942 Nebraska Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes XXXI Maryland Prince George's Suitland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5119 Clacton Avenue 20746 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏝 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify Specify <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Librarian Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer M. Rasmussen Myrtle M. Lee ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 S. Lakeview Drive West Des Moines, Iowa 50263 Richard Rasmussen / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 08/30/2007 4 Donation Kalas Crematory Edgewater, Maryland 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service Ligensee 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t page 2 s autopsy perform or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Other (Specify) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 1 🗌 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EWIA HNNAPOLIS m MICHAEL J.la 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

amendal Type of Print 17 Black Inderible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State amend 5-22 per F.H. g871 90 etimotate with Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jessyca Lee Stephens 11 2007 january /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER CHARLES LAPLATA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | O Month | Day Year) Birthplace (State or Foreign
 MCountry) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1 M 2 J Yrs. Director none Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at St. Mary's Mechanicsville 1 ☐ Yes X☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 27659 Vally Wood Court items 23a 20659 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🗓 No 9 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) infant 0 0 infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerry Lee stephens Elizabeth Lee Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra parents 27659 Vally Wood Court, St. Mary's, MD more, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Trinity Men gruns 1/15/07 N Burial 2 ☐ Cremation 3 ☐ Removal from State Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) Balti 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. Charlotte Hall, MD Joseph Barton Yates 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1∐ Yes 2☑No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 Lanpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 © Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ALI 3261

31. Date filed (Month, Day, Year)

32. Registrar's Signature

OLD WASHINGTON RD SUITE 1013 WALDORF, MD 20602

amend 1 per Dr. 9871 9/13/07 KBH. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 5-22 per F.H. KBH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $11 \quad 2\overset{\text{Year}}{007}$ Physician Jerry Lee Stephens, JR. january /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠** M 2□ F Months Days Hours none Director 8 1/11/07 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show a or 28a-f sh t be notified MD St. Mary's Mechanicsville Director 1 TYes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 27659 Vally Wood Court 20659 TISA or Items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 7 is marked other than "natural", or Iten traumatic event, the Medical Examiner 1 Yes X No If Yes, Give Year or Dates: 1X Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 0 infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerry Lee Stephens Elixabeth Lee Taylor ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parents 27659 Vally Wood Court, St. Mary's, MD. 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o once. Department of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Mem. grdns. 1/15/07 Waldorf, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility brinsfield- Echols Funeral Home, P.A. Charlotte Hall, MD. Joseph Burton Yates 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ktreme disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ U 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1□ Yes 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death | Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 252 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 A Natural after death.

I Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 27-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAID ALI3261 OLD WASHINGTON RD SUITE 1013 WALDORF, MD 20602 32. Registrar's Signature 31. Date filed (Month, Day, State 3 EP Registrar

07-06703 Marcus Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

OCME

2007 29492

			1- For State Certificate o	f Death	Reg.	No.	
1	- Physicia	an/	1. Decedent's Name (First, Middle,Last)		. 2. Date of Death Month D	ay Year	3. Time of Death 0658 hrs
1	l Exami		Marcus Andrew Smith	(Month Day August 29, 2	4c. County of Death	0656 1118
			Facility Name (if not institution, give street and number) Baltimore Washington Medical Center	4b. City, Town, or Location of Death Glen Burnie	No. 10	Anne Arundel	
	Formal		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	s. 8. Date of Birth (MM/DD/YYYY) 9. Birth	place (State or Foreign
	Funeral Director		220–19–3115 1XM 2_F 19 Yr	Months Days Hours Mir		Cou	ntry) yland
		L	Usual Residence of Decedent	<u> </u>	03/30/13	700 1222	
	any	_ <u>_</u>	10a. State 10b. County 10c. City, Town or Local				10d. Inside City Limits
	and show nce	اة	MD Millervill	ie			1 X Yes 2 No
9	e Maryland or 28a-f show any fied at once	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?
5	with the Maryland ns 23a or 28a-f sho be notified at once		268 Chalet Circle West	21108	7 //		na Indian Block
	th wit tems 2 at be r	Funeral	1 X Never Married 2 Married Armed Forces? If	as Decedent of Hispanic Origin? (\$ Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	14. Race - Americ White, etc.	arr Iridian, Black,
	er dea	1	1 Yes 2 A No	Yes 2 X No specify:		Specify: Bl	ack
	urs aft tural' amine	홠	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of		6b. Kind of Business/Ir	ndustry
	3 72 ho 11 "na 11 Ex	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use re	(tired)	Private	
	5-0036 led within 72 Hygiene other than the Medical	E G	1202	ing Clerk	ne (First, Middle, Ma		
	215-0036 be filed within 72 hours after death with the Maryland mall Hygiens do ther ham "natural", or items 23a or 28a-f she ent, the Medie I Examiner must be notified at once ent, the Medie I Examiner must be notified at once		17. Father's Name (First, Middle, Last) John R. Williams	Toya Sm		iden sumame,	
	21215-0036 Suld be filed within 7 I Mental Hygiene I marked other than ic event, the Medir	To Be	19a Informant's Name/Relationship (Type, Print)	ng Address (Street and Number of	Rural Route Number	er, City or Town, State,	Zip Code)
	O 4 5 5 5		Toya R. Smith - Mother 268 C	halet Circle West; M			
	e, ME l and 2 s Health a: item 27			osition (Name of cemetery, other place)	Date	20c. Location - City or	Town, State
	TOTE Pages ent of H nt: If i		Burial 2 Cremation 3 Removal from State		/06/2007	Laurel, Mary	yland
	Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr		21 Signature of Funeral Service Licensee 22.	Name and Address of Facility reeman Funeral Servi	4504 D-	and the mornal	20748
	o §9 ∏ ∐		234. Part I. Enter the disease or complications that caused the death. Do not enter	reeman Funeral Servi	ces 4594 be	t shock or heart	Approximate Interval
	`nysician ∠Medical		failure. List only one cause on each line.		or respiratory arros	t, shook, or hour	Between Onset and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Reactive airway disease Due to (or as a consequence of):	:			
			Sequentially list conditions, b				
		ner	if any, leading to immediate Due to (or as a consequence of):				
		Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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	760, cate be executed physician and the burial - transi	Medical	AMEAUSED AMEAUSED 27, perME, g872, 10/	11/07 TT			
	760, ficate be g physicist the buri		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic preg	nancy	23d. Date of deliver	y Day Year
	OX 687 eath certifi attending for use as t	ician	past 12 months? 4 Pregnant at time of death 5	Other (Specify)			
	Box 68 le death certif the attending	Physi	I 1 Yes 2 No 9 Hoknown I	La La la compania de la Compania De la La Compania de la Compania de la Compania de la Compania de la Compania	22o Did tob	acco use contribute to	the cause of death?
	Division of Vital Records, P.O. Box 68' rat or Attending Physician: The law requires that the death certif its after death. "All Director. After this certificate has been signed by the attending lin by the funeral director, page 2 should be detached for use as sell.	by P		e underlying cause given in Part I.		2 No 3 Pro	
	duires en sig uld be				24a. Was ar		utopsy findings available
	corc law re has be	ompleted			autops	ned? death?	completion of cause of
	Re(The ficate	Co		26.Place of Death (Che	1 Yes 2	No 1 ✓ Y	es 2 No
	Vital Rec hysician: The this certificate I director, page	Be	examiner? Hospital: 1 Innation: 2 FR/Outpaties	-Oth		Residence 6 Othe	r:
	n of V ing Phy: After thi funeral d	<u>ا</u> يا	27 Manner of Death 28a Date of Injury 28b. Time of		28d. Describe ho	ow injury occurred	
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	Division of Vital Recours dier dem or Attending Physician: The 1 ours after death everal Director. After this certificate I filled in by the funeral director, page	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, si	treet, factory, office building, etc.	28f. Location (St or Town, St		ural Route Number, City
	Dispital cours a reral I	Cer					
	Division of Vital Records, P.O. Box 683. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as st	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death ocone) Wedical Examiner: On the basis of examination and/or investi	curred at the time, date and place, a gation, in my opinion, death occurre	and due to the cause ad at the time, date a	e(s) and manner as sta and place, and due to the	ted. ne cause(s)
	To th withi To th	Medi	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	
		2	250. Signibility and the or willing	O.C.M.E.		August 30, 2007	
Λ			30. Name and address of person who completed cause of death (Item 23a)				
K	- U		Jack Titus MD Deputy Chief Medical Examiner 111 P	enn Street, Baltimore, MD	21201		
		tate	31. Date filed (Month, Day, Year). SFD 1 0 2007	,			

				Maryland		rtment of H		and Me			00100		
	A		State Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Death		Reg.	No 2007	29493		
	Physic		BENJAMIN JAMES SMITH						Month	R 1, 2907	3. Time of Death		
	/Medi Examir		4a. Facility Name (If not institution, give street and number	ber)		4b. City, Town, or	Location o		DEFIEMDE	4c. County of Death	1:00 PM		
			REEDERS MEMORIAL HOME				BOONS				HINGTON		
مائد ا	Funeral Director		219-14-8082 ¹ ₩ 2□ F	'. Age (In yrs. last 84	t birthday) Yrs.	Months Days	If Under 2 Hours	Min. O	Date of Birth (Month, Day, Yo CT. 12,	1922 9. Birthpl Coun M	ace (State or Foreign (RYLAND		
	land ow t		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Loc	ation				10	Od. Inside City Limits		
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	th the or 28s e noti	Sirec	10e. Street and Number			10f. Zip Code			10g.	Citizen of What Coun	try?		
	ath wi	ral	141 S. MAIN STREET				1713			U.S.A			
J. 036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1	X] No		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2☐XNo	spanic Orig n, Mexican Specify:	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)	14. Race - America Black, White, e	etc.		
in J. 5-0036	72 hor natur lical E	eted	15. Decedent's Education (Specify only highest grade completed)	1	6a. Deced	ent's Usual Occupa	ation	of working	16	o. Kind of Business/Ind			
Benjamin Ind 21215-	vithin ane. ihan "	Completed by	Elementary/Secondary (0-12) College (1-4	tor 5+)	life. D	O NOT use retired,)	5		Collambia			
d 2	filed \ Hygie other I	e Co	17. Father's Name (First, Middle, Last)			MASON T			First, Middle, Mai	CONSTRUC	CITON		
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Name: Smith, Ber Baltimore, Maryland	1 and 2 shou Health and N em 27 is ma other trauma		19a. Informant's Name/Relationship (Type. Print) WILLIAM L. SMITH, BROTH							ity or Town, State, Zip DRO,MARYLLA			
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Name:	permit. Pag Department Important: I any Injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. prinature (1 uner Struck Licensee	BOONS		CEMETERY		/5/20	07 B0	OONSBORO, N	1ARYLAND		
Sa Ba	permit. Departr Importa any Inji		21. It has the service Licensee			Name and Addres		ME /b		NATIONAL PI MARYLAND	IKE 2 1 713		
8760,	Physician /Medical Examiner be executed street by the prival-transit stree	dical Examiner	23a. Part I. Injer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation interval B only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
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Reco	sician: The law re s certificate has bee irector, page 2 sho	Completed by							24a. Was an autopsy performed	24b. Were autop prior to com	sy findings available apletion of cause of		
ta	an: T lificate or, pa	ပိ	25. Was case referred to medical				26 Bloom	of Dooth (C	1□ Yes 2 Z		2 ☐ No		
<u> </u>	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inp	atient 2 ☐ ER/	Outpatient	3 DOA Othe			5 Residence	e 6 ☐Other (Specify,)		
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Division or Vital Records, P.O	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident Investigation	f injury - At home, , etc. <i>(Sp</i> ec <i>ify)</i>	, farm, stree	M 1 □ Y	es 2 □ N		Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,		
	le Hospitz 24 hours ne Funera	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner and man	is of examination	dge, death and/or inve	occurred at the timestigation, in my op	e, date and inion, deat	l place, and h occurred	I due to the caus at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)		
	To th Vithii To th COMP	Me	29b. Signature and title of certifier			29c. License				Date signed (Month, E	Day, Year)		
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05/	4-3			YAND DR.	a) (Type, P	rint) DYSVILLE ,	MD217	56					
	Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP 0 4 2007	istrar's Signature	Spen	W.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Cecil Co. 8/31/07 rjw to. 8/31/07 rjw State of Maryland / Department of Health and Mental Hygiene 1- State Item# 9,17,18 Certificate of Death Reg. No. 2007 Amend 29494 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** 28, 2007 4c. County of Death 14:30 Annelies H. Skorak 49451 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital Cecil E1kton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Days Hours Min 1 □ M 2 TF Director 440-38-0520 82 26 1925 te Germany Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2XXNo Director Maryland Cecil **Elkton** the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 201 Paige Lane USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23.
Lry or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify. Specify. 3€ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elise Elise Klingauf unknown Wilhelm Huhn unknown 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward W. Skorak 201 Paige Ln, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 □Removal from State permit. Page Department o Important: If any Injury or once. Mayerdale Crematory 4 ☐ Donation 5/ Other (Spec Aug 31 2007 Newark, DE 21. Signature of Juneral Service 22. Name and Address of Facility Spicer-Mullikin FH 1000 N DuPont Pky New Castle DE nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Part1. Enter the disease, or complication shock, or heart failure. List only on a ca Due to (or as a consequence of): Immediate Cause (Final **Physician** 8 days disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year ned by the an 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 2 filled in by the funeral dir this s after death. 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 131 N Bridge St. ElkTon, MD 31. Date filed (Month, Day, Year) State AUG 3 0 Registrar

07-06953 Sandra J. Stein

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Di	1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last)	Reg. No. 2007 294						
Physician/ al Examiner		Month Day Year September 7, 2007 0810 hrs						
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De Silver Spring							
Funeral Director	104-30-0657 1 M 2 X F 67 Yrs.	Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign CountryNew York)						
how any:	Usual Residence of Decedent 10a. State	10d. Inside City Limits 1 X Yes 2 No						
h the Maryland 3a or 28a-f show totified at once.	10e. Street and Number 10f. Zip Code 20906	. 10g. Citizen of What Country? United States						
er death wit , or items? r must be r	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put							
an "natural" cal Examine	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	of work done 16b. Kind of Business/Industry						
be filed within 72 hour ntal Hygiene. -ked other than "natt ent, the Medical Exar Be Completed		ame (First, Middle, Maiden Surname) an Goldman						
D E F 61 m	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route Number, City or Town, State, Zip Code) Chevy Chase MD 20815						
permit. Pages I and 2 should Department of Health and Mc Important: If item 27 is ma injury or other traumatic er	4 Donation 5 Other Specify:	Date 20c. Location - City or Town, State /10/2007 Olney, MD						
Departing Departing Importing Injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Janzans ky – Goldber II/0 Rockville	g Memorial Chapels Inc ike Rockville MD 20852						
nysician Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line. Immediate Cause (Final disease	ac or respiratory arrest, shock, or heart Approximate interval Between Onset and Death						
er	or condition resulting in death) Due to (or as a consequence of): b. Due to (or as a consequence of): b. Due to (or as a consequence of):							
t ansit Examine	Course. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
icate be executed physician and the burial - transit	X UNPENDED AMENDED #23,27,28a-f, perME,g872, 10/1/07 TT IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery						
the death certificat by the attending ph ched for use as the Physician/IV								
s that the death certiff gned by the attending e detached for use as a		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknow						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical E.		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No						
ysician: The law his certificate has director, page 2 s	25. Was case referred to medical examiner? Hospital: Incation: 2 EP/Outnation: 3 DOA Other Ni							
tal or Attending Physician: The law requires that the safter death. "Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled in the funeral or to be Completed by Fertification: To Be Completed by Fertification:	27. Manner of Death 28a. Date of Injury (Month, Dey, Year) Natural 5 Pending Find O/7/2007 Find 8-10 pm 1 Yes 2 X No	28d. Describe how injury occurred						
spital or Attending hours after death. meral Director: After y filled in by the fune Certification:	2 Accident Investigation 3 X Suicide 6 Could not be determined (Specify) residence 1 Accident Investigation PTR 9/1/2007 FTR 5:10 pth 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. 1 (Specify) residence	28f. Location (Street and Number or Rural Route Number, City or Town, State) 3210 Norbeck Rd. Silver Spring, MD						
To the Hosp within 24 hos To the Fune completely fi	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, one)	red at the time, date and place, and due to the cause(s)						
N N	Thrown U. F. & Thy man O.C.M.E.	September 8, 2007						
	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltim	nore, MD 21201						
State Registra								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. 29496

Amend Items 23a, Pt. LII, 25, 27, 28a-f. per MF. C872, 10/02/0/dib
State of Maryland Department of Health and Mental Hygiene

			1 - For Stata Registrar		2 State of	Maryland		intment of the tificate of		Mental Hyg	g. No.		
-	Physici	an	Decedent's Name							2. Date of Deat Month	h Day Year	3. Time of Death	
	/Medi									August	25 2007	9:05 A M	
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death							ו	4c. County of Deat		
	1982	Verse				A (1		Knoxvi			Frederick		
	Funeral		5. Social Security Nu 214-16-1		6. Sex 7.	Age (In yrs. Ia:	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Foreign nuntry)	
	Director		Usual Residence of		Λ	80				Aug 26	1920 Pet	ersville MD	
	/land	Funeral Director	10a. State	10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits	
	Man Hed		MD	Frede	rick		Knoxv	i11e		1 ☐ Yes 21⁄2 N			
	r 28s		10e. Street and Number 10f. Zip Code						10	ng. Citizen of What Co	ountry?		
	23a o	a D	620 Knoxville Road 21758				1758		USA				
	dea	ner	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?			ent Ever in U.S	. 13.	Was Decedent of H	14. Race - American Indian, Black, White, etc.				
9	or Ite		1 Never Marrie		ned 1 TYes 2	□No		1 ☐ Yes 2 ☐ No		o (1104), 0(0.)	Specify:	e, etc.	
00	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow dissal Examiliae must be notified at	d by	3 □XWidowed 4		Year or Date	s: WWII					Wh	ite	
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12	withir ane. than		Elementary/Secon	ndary (0-12)	College (1-4	or 5+)		akeman	0)	B&O Railroad			
Maryland 21215-0036	Hygid ther ther		17. Father's Name (/	First, Middle,	Last)		DI	ancillati	18. Mother's Nar	ne (First, Middle, M		oau	
	d be		Arthur	Daniel	Simons					11e Kidwe			
	Shoul od Me mark	Ĕ	19a. Informant's Na				19b. Mailir	ng Address (Street			City or Town, State, 2	Zip Code)	
	ulth an 27 is		Jovce Tr	wioo	Daughter		20	each Tree		623		,	
ē,	f Heal		20a. Method of Disp	osition		007	ce of Dispo	sition (Name of natory or other pla		Ranson,	WV 25 138 20c. Location - City or	Town, State	
Baltimore,	Page ent o nt: If ry or		1 🔲 Burial 2 🗓 4 🗎 Donation		3 □Removal from Sta			vn Cremat		7/07 H	Hagerstown	MD	
at:	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Example international be notified at ance.		21. Si pater of Fr	-	and the same of the same of the	Enen						, 112	
ä	Depar Impo		21. Sinding of Progral Service Ceen. 19 22. Name and Address of Facility John T. Williams Funeral Home 100 Potorsyilla Road Program of Mp. 21716										
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate									Approximate	
	Physician												
7	/Medical		disease or condition resulting in death) a. Unout Obstachor (almonto) Due to (or as a consequence of):								4 4 667		
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			IF FEMALE:		23c. If yes, outcome	mo of aronnon							
Вох	death certif e attending id for use as	lan	23b. Was decedent in the past 12 r	nonths?	1 Live birth	n 2 ☐ Fetal d	leath 3	Ectopic pregnanc	/		23d. Date of del Month	ivery Day Year	
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Ö	v req	lete		Co.	runger Au	rtu	Dick	or Dal D		24a. Was ar	24h Woro au	topsy findings available	
Œ ,	0 C 9	Completed			aunothorax		() ()	or, KID FI	acture with	perform	prior to death?	completion of cause of	
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o	g Phys er this eral dii	7: To	27. Manner of Death		28a. Date of I		8b. Time of			28d. Describe ho		шу)	
Vision Attending r death.	ath. r: After e tuner	atlo	1 Shatural 5 Pending investigation 2 X Coident 3 Suicide 4 Homicide 4 Homicide 1 Representation 1 Shallow 1 Representation 2 Representation 2 See Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						Subject fell				
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Ö	s after sale		4 Homicide building, etc. (Specify) Nursing Hone						Frederick.	City or Town, State) 30 North Place, rederick, MD			
	hour hour ner		29a. Certifier (Check only	1 Certifyin	ig Physician: To the be	est of my knowl	ledge, death	occurred at the til	ne, date and place	, and due to the ca	use(s) and manner as	stated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical	one)		Examiner: On the basis and manner	stated.	aranaroi in						
	To To	Σ	29b. Signature and	/ //	un MD	,		29c. Licens	_	29	d. Date signed (Monta		
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5	M		30. Name and addre	ss of person	who completed cause of		23a) (Type,	Print)	Accid	£ ~	-/ //	2/7/	
			31. Date filed (Month	Day Vocal	and Mo	istrar's Signatu	60	MINTH	AUE	Brunic	vict Mi	21/16	
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State of Maryland / Department of Health and Me	ental Hygiene	
ctate of marytand / Department of Health and Mic	intai riygiono U	i

cian	1. Decedent's Name (First, Middle, La	ist)	Cer	tificate of D	eaur	Reg.	No.	3. Time of Death	
	Kalman Gyu					Month #	Day Year		
al er	4a. Facility Name (If not institution, given			4b. City, Town, or L	ocation of Death	Maya X	4c. County of Dea		
	18 Kermagrin Way				East	10.0	Cecil		
	221-20-0076	Sex. 7. Age (In 8	yrs. last birthday). 7 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye June 4,19	920 Hu	rthplace (State or Forei Country) ingary	
	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limi	
ctor	Maryland Ceci	1	Rising	Sun				1 ☐ Yes 2 🖔 N	
Dire	10e. Street and Number					Citizen of What C			
erai	553 Goosemar Ro	21914			United S				
by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ ☐ Mover Married 2 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 VNo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XXNo Specify:			Black, White, etc. Specify: White			
Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	ent's Usual Occupati	ion ring most of work	kina 16t	16b. Kind of Business/Industry		
mpic	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done du DO NOT use retired)			Manufactu	.rina	
	17. Father's Name (First, Middle, Last	")	C1V1	L Engineer		ne (First, Middle, Mai		ILTIIG	
To Be	Gyula Szkal				Anna K		,		
	19a. Informant's Name/Relationship					ral Route Number, C	•		
	Kathy Dean / Dau		18 Ke1			h East, Ma		21901	
	20a. Method of Disposition 1 Burial 2 XCremation 3	Removal from State	cemetery, cren	natory or other place)	-		. Location - City o		
	' 4 □ Donation 5 □ Other (Special Signature of Funeral Sovice Lies			Cremator Name and Address		rouch Fune	wark, De		
dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Clause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):								
Jedicai	IE SELVIE						1		
o in by the function director, page 2 should be detached for use as sertification: To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time 9 Unknown	23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
						24a. Was an autopsy performed 1 Yes 24	prior to	autopsy findings availa completion of cause of	
	25. Was case referred to medical examiner?	Hospital:		Other:		th (Check only one)		Presentes 's	
	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	3 DOA 4 Nursing Home 5 Resi			how injury occurred			
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Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	con Cination of adding !			29c. License r	number	29d.	Date signed (Mor	th Day Year)	
Me	29b. Signature and title of certifier			_				30,2007	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Virginia Stone August 2007 12:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Crescent Center Riverdale, Fix.

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Woothe | Davs | Hours | Min. | February | 8,1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign
Country) 1 ☐ M 2 😾 F 578-26-2396 88 Yrs. Washington, D. Director Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c, City, Town or Location 17 is marked other than "natural, or items 23a or 28a-f show traumatic event, the Mudical Evantual be notified at 10d. Inside City Limits 1 Yes 2 No Directo Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4409 East West Highway 20737 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Twelth Census Bureau 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Stone Minnie Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 821 Barnaby Street SE Washington DC 20032 Barbara Jenes-Kenner/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) August 31, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Riverdale Crematory ` 4 ☐ Donation 5 ☐ Other (Specify) 2007 Riverdale Maryland 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Carressons Long Onset and Death Physician 14Lan /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 □ No 3 ☐ Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2€No Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Aursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of After I Certification: 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral I Medical 29a. Certifier t 📑 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01852 ath (Item 23a) (Type, Print) B QUEENSLUM De Hyartsville MD 20781 State Registrar

ampril 2/2 25 26 of Frint in Black Indentitie Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death amend 10efg, 15, 16ab, per KBH Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year /Medical 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimare Baltimore, 01 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Sex 1 X M 2 □ F 0 Director 31 mardland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits be notified at Director Himor 1 Yes 2 No ML 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7109 Ruthereen Rd Funeral TISA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify by Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ahinmodeyemi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iblulopt: Irria mother Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State ALTIMORC. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2400 W. BelveDeRe A Im. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EXTREME /Medical Examiner INCOMPETENT CERVIX Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ETERM burial-tran Division or Vital Records, P.O. Box 68760. Physician/Medical use If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery For 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 1□ Yes 2**√** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4/ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check of 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a (Type, Print) Geha T. Manley M.D.
31. Date filed (Month, Day, Year)
SEP 1 3 2007 Gena T. 2401 W. Belvedere Ave. Baltimore, MD

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August **Physician** isto 200 VOVPYS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner pkins Baltimore Ho Birthplace (State or Foreign Country) Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**⊠**M 2□F 264-08-7504 53 03/23/1954 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show of al Examiner must be notified at 1 X Yes 2 ☐ No Director MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 US 63 Broadway, Apt. 1 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. e filed within 72 hours after on Hygiene. I hygiene. I other than "natural", or iter 1 ∐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2X No Specify: 3altimore, Maryland 21215-0036 Completed by 3 Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Jean (unk) Hill n and Mental Wallace Edward Travers ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1410 Pennsylvania Avenue, Durham, NC 27705 Kathy Travers / Sister Health Item 27 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Pages 1 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State injury or Department of Important: If any injury or once. Smithsburg Crematory 09/01/2007 Smithsburg, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Foreral Source Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1conol Zyears Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exam burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as 1 IF FEMALE use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy pertormed? Yes 2 No certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 11 Inpatient Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) оmpletely within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tohns

Hookins Hospital, 600 North Wolfe Street, Baltimore, Manyl and 21287 32. Registrar's Signature

September